MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10072

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 1

1. PLACE OF DEATH:
COUNTY A.A Cty — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN HERALD HARBOR — LENGTH OF STAY (In this place) 27 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS SOUTH RIVER SIDE

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY A.A Cty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HERALD HARBOR
STREET ADDRESS (If rural, give location) SOUTH RIVER SIDE

3. NAME OF DECEASED: (First) OTTO (Middle) WILLIAM (Last) AHLGREN
4. DATE OF DEATH: (Month) 1 (Day) 10 (Year) 1953
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: 3-22-1877
9. AGE last birthday: 75 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired-worked for State of Maryland
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): SWEDEN
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ✓
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: SON: CHAS. AHLGREN

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Degeneration, General Kachexia	6 mos.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Cancer of the prostate gland ?	3 years
	DUE TO (c) multiple metastases	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

177

19a. DATE OF OPERATION: 6 years ago
19b. MAJOR FINDINGS OF OPERATION: Cancer of prostate gland
20. AUTOPSY? Yes ☐ No ✓

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) 1 10 1953 9 A.M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 9 19 53, to 1/10/53 19, that I last saw the deceased alive on 1/7/53, 19, and that death occurred at 9:55 a.m., from the causes and on the date stated above.

SIGNATURE L Benedict (DEGREE OR TITLE) M.D. ADDRESS CROWNSVILLE, Md DATE SIGNED 1/10/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF Jan 12/53
NAME OF CEMETERY OR CREMATORY Baldwin Memorial
LOCATION (City, town, or county) (State) Millersville Md
DATE REC'D BY LOCAL REG. Jan. 12, 1953
REGISTRAR'S SIGNATURE H. C. Dowell
24. FUNERAL DIRECTOR ADDRESS B. L. Hupman & Son

G.W.

RECEIVED
JAN 16 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00023

CERTIFICATE OF DEATH

Reg. Dist. No. .....

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

1. PLACE OF DEATH:

COUNTY Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severn

LENGTH OF STAY (in this place): Life

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 9 W Camp Meade Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland — COUNTY A. A. Co.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severn

STREET ADDRESS (If rural give location): 9 W. Camp Meade Rd.

3. NAME OF DECEASED: (Type or Print) (First) Amy (Middle) Ellison (Last) Allen

4. DATE OF DEATH: (Month) Jan. (Day) 10 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Dec. 3 1873

9. AGE last birthday: 79 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Telegrapher (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: P. R. R.

11. BIRTHPLACE (State or foreign country): Anne Arundel Co. Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William [illegible] Allen

14. MOTHER'S MAIDEN NAME: Martha Warfield

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs. Kenneth Carter — 1505 Pentridge Rd. Baltimore, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause (a) Cerebro-Vascular Disease — Interval Between Onset And Death: 1 yr.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Hypertension — 10 Yrs.

DUE TO

(c) Gastroenteritis — 2 days

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1940, to 1/10/53, that I last saw the deceased alive on 1/10, 1953, and that death occurred at 9 P., from the causes and on the date stated above.

SIGNATURE: Chas. L. Ball Jr. — (Degree or title) — ADDRESS: Linthicum — DATE SIGNED: 1/10/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1-12-53 — NAME OF CEMETERY OR CREMATORY: Glen Haven — LOCATION (City, town, or county) (State): Glen Burnie, Md.

DATE REC'D BY LOCAL REGISTRAR: 1/13/53 — REGISTRAR'S SIGNATURE: [illegible] D. Albert

24. FUNERAL DIRECTOR: R V Singleton — ADDRESS: Glen Burnie, Md.

VS. A1

RECEIVED
JAN 14 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1003

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
STREET ADDRESS (If rural, give location): 767 Mosher Street

3. NAME OF DECEASED: (Type or Print) (First) Sarah (Middle) (Last) Allen

4. DATE OF DEATH: (Month) 1 (Day) 31 (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1902?

9. AGE last birthday: 51? yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Rosa Chase

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) — — —

16. SOCIAL SECURITY NO.: — — — —

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 422.2

Immediate cause (a) Very far progressed degeneration of the heart muscle with atrophy — Interval between onset and death: Unknown

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO

(c) DUE TO

(OK)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Chronic Brain Syndrome associated with Syphilis of the Central Nervous System with Psychotic Reaction — 7 years

19a. DATE OF OPERATION: — — — — —

19b. MAJOR FINDINGS OF OPERATION: — — — — — — — — — — — — — — — — — —

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — — — — — —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — — — — —

(CITY OR TOWN) (COUNTY) (STATE) — — — — — — — — — — — — — — — — — —

TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — — M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR? — — — — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 1/29, 19 53, to 1/31 19 53, that I last saw the deceased alive on 1/31 19 53 and that death occurred at 6:20 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Carl Hungerford M.D. — ADDRESS Crownsville, Md. — DATE SIGNED 1/31/53

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/7/1953	Mt. Lebanon Cem.	Balto.	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/5/53	A. W. Hedrick	Wm. Baker R. Williams	Baltimore 22

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00674

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Brownswoods
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY A. A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brownswoods
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Jeanette (Middle) Inlow (Last) Anderson

4. DATE OF DEATH: (Month) Jan. (Day) 24 (Year) 1953

5. SEX: Fem. | 6. COLOR OR RACE: Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH: 3/18/1882 | 9. AGE last Birthday: 70 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Domestic | 10b. KIND OF BUSINESS OR INDUSTRY: Housework | 11. BIRTHPLACE (State or foreign country): A. A. Co | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Little | 14. MOTHER'S MAIDEN NAME: Henretta Little

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No.: | 17. INFORMANT & ADDRESS: Amos Anderson

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause (a) Ch. Nephritis & Malnia — Interval Between Onset And Death: 48 hrs.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerotic C.V. disease & hypertension — yrs.

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Operated 9yrs ago, CA of L. breast at J.H.Hop.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1947, to 1/23, 1953, that I last saw the deceased alive on 1/22, 1953, and that death occurred at 11.05 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) Mamie K Lewis, MD | ADDRESS Annapolis, Md | DATE SIGNED 1/26/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 1/27/53 | NAME OF CEMETERY OR CREMATORY Broadneck | LOCATION (City, town, or county) St. Margarets | (State) Md

DATE REC'D BY LOCAL REGISTRAR Jan. 26, 1953 | REGISTRAR'S SIGNATURE J. O'Donnell B.W. | 24. FUNERAL DIRECTOR J. B. Johnson | ADDRESS Annapolis

RECEIVED
JAN 27 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00075 24

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Bay Harbor (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs

Hospital, Institution, or street address where death occurred: Tucknock Road

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Bay Harbor (If outside city or town limits, write RURAL and give nearest town)

Street No.: Tucknock Road (If rural, give LOCATION)

2.(a) If veteran, name war: No veteran

3.(a) FULL NAME MARGARET ARBOGAST

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Ira Arbogast

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 22, 1881

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
71	—	29		

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER 12. Name: Alfred Aquiles

13. Birthplace .....

MOTHER 14. Maiden name: Annie Nichols

15. Birthplace .....

16. Informant: Ira Arbogast

Address: 4908 Curtis Ave. Balto. 26 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/23/53 (month) (day) (year)

Cemetery or crematory: Lorraine Park Cem

Location: Woodlawn, Md.

18. Funeral director: Easton Sons

Address: 608 Frederick Ave. Easton Md.

19. 1/23 19 53 (Date rec'd by registrar) T. J. Di alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 20 19 53 at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 52 to Jan 20 19 53 and that I last saw h.er alive on Jan 20 19 53

Immediate cause of death	DURATION
Coronary Thrombosis	1 minute
Due to: Coronary Sclerosis	5 years
Due to: 260+ Diabetis Mellitus	10 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Brady Smith M.D. M. D. or other

Address: Riviera Beach Md. Date signed: 1/20/53

RECEIVED
JAN 28 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00074 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 51

1. PLACE OF DEATH:

COUNTY: Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General (DOA)

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Md — COUNTY: Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mayo

STREET ADDRESS (If rural, give location): Edgewater Post Office

3. NAME OF DECEASED: (Type or Print) (First) MARY ANN (Middle) BAKER (Last) Baker

4. DATE OF DEATH: (Month) Jan. (Day) 11, (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 3, 1894

9. AGE last birthday: 58 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Anne Arundel County Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Ball

14. MOTHER'S MAIDEN NAME: Fanny Ford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: 216-18-4941

17. INFORMANT & ADDRESS: James E. Baker- Husband- same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	1 hr
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Arteriosclerotic Cardiovascular disease	10 yrs
DUE TO		
	(c)	

420

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 45, to Jan 11, 53, that I last saw the deceased alive on June 9, 53, and that death occurred at 9 07 a m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS: J. Bosworth M.D. Annapolis, Md — DATE SIGNED: 1/11/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Jan 14, 53

NAME OF CEMETERY OR CREMATORY: Episcopal Cemetery

LOCATION (City, town, or county) (State): Mayo, Md.

DATE REC'D BY LOCAL REG.: Jan. 12, 1953

REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR ADDRESS: Ben L. Hopping and Son Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 11

1. PLACE OF DEATH:

COUNTY Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis

STREET ADDRESS (If rural, give location) 141 Poplar St.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month) (Day) (Year)
Virgie		Beall	January 31, 19 53

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	May 26, 1890	62 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
House wife	own home	Calvert County, Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
James King	Ida Carr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no — no	None	Robert G. Beall Son [illegible] as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
331X Immediate cause	(a) Aspiration Pneumonia	2 days.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Vomiting	2-3 days
	(c) DUE TO Cerebral Vascular Accident	4 weeks.

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 1-25, 1953, to 1-30, 1953, that I last saw the deceased alive on 1-30, 1953, and that death occurred at 1:00 A.m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
Edward S. Beck	M.D.	4 Southgate Ave Annapolis	2-4-53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, Town, or county) (State)
Burial	2-3-53	Edwards Chapel	Annapolis, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 3, 1953	[signature] B.W.	Ben L. Hopkins & Son	Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md — COUNTY Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn

STREET ADDRESS (If rural, give location) RFD # 1 Box 67

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) LEE (Last) BLAIR

4. DATE OF DEATH: (Month) Jan (Day) 4, (Year) 1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Single	12/24/52	0 yrs.	10	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ----

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Blair

14. MOTHER'S MAIDEN NAME: Esther Spyk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ---- (If Yes, give war or dates of service) ----

16. SOCIAL SECURITY NO.: ----

17. INFORMANT & ADDRESS: Mr. George E. Blair Father same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) SUBARACHNOID HEMORRHAGE — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) — DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH: Brain on

760?

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Brent, 19....., to 4 Jan, 19 53, that I last saw the deceased alive on 4 Jan, 19 53, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE Philip Brent M.D. (DEGREE OR TITLE) ADDRESS 212 Prince George DATE SIGNED 1/4/53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 5 53	Glen Haven Cemetery	Glen Burnie, Md.

DATE REC'D BY LOCAL REG. Jan. 5, 1953

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS: Ben L. Hopping and Son Annapolis, Md.

20V2273405

RECEIVED
JAN 7 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:

COUNTY: Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville, Md.

LENGTH OF STAY (in this place): 7½ months

HOSPITAL OR INSTITUTION OR STREET ADDRESS: State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Md. COUNTY: Baltimore City

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore, Md.

STREET ADDRESS (If rural, give location): 1609 E. Chase Street ✓

3. NAME OF DECEASED: (Type or Print) (First) Jacqueline (Middle) B utler (Last)

4. DATE OF DEATH: (Month) Jan. (Day) 15 (Year) 19 53

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Negro	single	Jan. 4, 1951	2 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore City	U. S.

13. FATHER'S NAME: Eugene Butler

14. MOTHER'S MAIDEN NAME: Elaine Owens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
		Mrs. Elaine Butler, mother, 1609 E. Chase St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchopneumonia	about 3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b)	
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Spastic Quadriplegia — known to us since 5/29/52

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 5/29/52, 19 52 to 1/15, 19 53, that I last saw the deceased alive on 1/15, 19 53 and that death occurred at 12:45 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

Crownsville State Hospital, Md.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-20-53	Mt Calvary	A A. County Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/16/53	A W Redrick	Wm J & Elliott	1129 N Carrollst

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 1

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 5 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): Carr's Corner

3. NAME OF DECEASED: (Type or Print) (First) Nancy (Middle) Jane (Last) CAMPBELL

4. DATE OF DEATH: (Month) January (Day) 8 (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: August 9, 1951

9. AGE last birthday: 1 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lawrence George CAMPBELL

14. MOTHER'S MAIDEN NAME: Gloria Hazel RUHL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Hospital records - USNH Annapolis, Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause	(a) PERIPHERAL CIRCULATORY FAILURE (782.9)	30 min
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) GASTROINTESTINAL TOXAEMIA (578)	12 hrs
	DUE TO (c) ENTEROCOLITIS FOLLOWING INJESTION OF SEWERAGE (571.0)	2 days
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.	MESENTERIC LYMPHADENITIS (468.1)	Unknown

571.0

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [X] No [ ]

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work [ ] Not while at work [ ]

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 Jan, 19 53, to 8 Jan, 19 53, that I last saw the deceased alive on 8 Jan, 19 53, and that death occurred at 2:20 p.m., from the causes and on the date stated above.

SIGNATURE: W.T. McKIRK, LCDR MC USN
(DEGREE OR TITLE) ADDRESS: U.S. Naval Hospital, Annapolis, Md.
DATE SIGNED: 1-9-53

23. BURIAL, CREMATION REMOVAL (Specify): Removal
DATE THEREOF: 9/8/1953
NAME OF CEMETERY OR CREMATORY: to
LOCATION (City, town, or county) (State): Ridgewood, N.J.

DATE REC'D BY LOCAL REG.: Jan. 9, 1953
REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: Ben L. Hopping and Son
ADDRESS: Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information requested. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY A A — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. G. General

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 166 Gloucester

3. NAME OF DECEASED: (Type or Print) (First) Addie (Middle) F. (Last) Carlson

4. DATE OF DEATH: (Month) 1 (Day) 22 (Year) 1953

5. SEX: F

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Mar. 4 1885

9. AGE last birthday: 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Annapolis Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John V. Beall

14. MOTHER'S MAIDEN NAME: Mary G. Lamb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): —
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: J Lawrence Carlson Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.0
Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: 4 h.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Arteriosclerotic Heart Disease — Interval: Unk

DUE TO

260X
(c) Generalized Arteriosclerosis — Interval: Unk

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — Interval: Unk

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION: — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1952 to Jan 22, 1953, that I last saw the deceased alive on Jan 22, 1953, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED
Ruth C Bond M. D. Annapolis Md 1-24-53

23. BURIAL, CREMATION, REMOVAL (Specify): — DATE THEREOF 1-24-53 — NAME OF CEMETERY OR CREMATORY Cedar Bluff — LOCATION (City, town, or county) Annapolis — (State) Md

DATE REC'D BY LOCAL REG. Jan. 24, 1953 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR John H. Taylor Sons — ADDRESS Annapolis Md.

RECEIVED
JAN 27 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 1

1. PLACE OF DEATH:
COUNTY A. A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Annapolis, Md.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A.A.Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN South Haven
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (First) MABEL (Middle) B. (Last) Carneal (Type or Print)

4. DATE OF DEATH: (Month) 1 (Day) 12 (Year) 1953

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH: 5/4/1911

9. AGE last birthday: 41 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY: Home work

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Bryant

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Barney Branham

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

642.2

Immediate cause (a) Pulmonary edema — DUE TO — Interval Between Onset and Death: 3 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Cardiac failure — DUE TO — 3 days

(c) Chronic hypertension, superimposed pulmonary edema — ? years

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/2, 1953 to 1/12, 1953, that I last saw the deceased alive on 1/12, 1953 and that death occurred at 4:55 a.m., from the causes and on the date stated above.

SIGNATURE J. M. Christley Jr. (DEGREE OR TITLE) MD ADDRESS 69 Franklin-Annapolis. DATE SIGNED 1/12/53

23. BURIAL, CREMATION, REMOVAL (Specify): DATE THEREOF 1/15/1953 NAME OF CEMETERY OR CREMATORY Annapolis National LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Jan. 15, 1953 REGISTRAR'S SIGNATURE [illegible] Deputy

24. FUNERAL DIRECTOR John M. Toy Sons. ADDRESS Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 61 Shaw Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 61 Shaw Street

3. NAME OF DECEASED (Type or Print): (First) Carroll (Middle) COATES (Last) Carr

4. DATE OF DEATH: (Month) Jan. (Day) 20, (Year) 1953

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: July, 1900

9. AGE last birthday: 52 yrs. — If under 1 year: Months 6 / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): A.A.CO..MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Coates

14. MOTHER'S MAIDEN NAME: Harriet Pinkney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Robert Coates, Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Functional Disease of the Heart	2-3 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	3+ yrs.
	(c)	

443X

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 16, 1953, to Jan 20, 1953, that I last saw the deceased alive on Jan 20, 1953, and that death occurred at 2:45 p.m., from the causes and on the date stated above.

SIGNATURE: Faye Allen (Degree or title) M.D. ADDRESS: 10 Carroll DATE SIGNED: 1-22-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Jan. 23, 1953 — NAME OF CEMETERY OR CREMATORY: Annapolis Neck — LOCATION (City, town, or county) (State): Annapolis Neck, Md.

DATE REC'D BY LOCAL REG.: Jan. 23, 1953 — REGISTRAR'S SIGNATURE: J. B. Johnson Reg.

24. FUNERAL DIRECTOR: J.B. Johnson — ADDRESS: Annapolis, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G Meade
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G Meade
STREET ADDRESS (If rural give location) 1906-B Patton Drive

3. NAME OF DECEASED: (Type or Print) (First) David (Middle) Sean (Last) Casey III

4. DATE OF DEATH: (Month) January (Day) 26 (Year) 1953

5. SEX: male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Premature

8. DATE OF BIRTH: 26 January 53

9. AGE last birthday: yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min. 50

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): -

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edgar Lawrence Casey

14. MOTHER'S MAIDEN NAME: Patricia LaVerne Young

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) -

16. SOCIAL SECURITY NO.: -

17. INFORMANT & ADDRESS: Mother

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

765.4

Immediate cause (a) Congenital Atelectasis

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Prematurity

DUE TO (c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. -

19a. DATE OF OPERATION: -

19b. MAJOR FINDINGS OF OPERATION -

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) -

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from 26 Jan, 1953, to 26 Jan, 1953, that I last saw the deceased alive on 26 Jan, 1953, and that death occurred at 0220 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Joseph L Shulman Capt MC — ADDRESS Fort George G Meade, Md. — DATE SIGNED 26 Jan 53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 27 Jan 53 — NAME OF CEMETERY OR CREMATORY Post Cemetary — LOCATION (City, town, or county) (State) Fort George G Meade, Md.

DATE REC'D BY LOCAL REGISTRAR 26 Jan 53 — REGISTRAR'S SIGNATURE Arthur J Gombos Capt MSC

24. FUNERAL DIRECTOR HIRAM W TROSTEL Chaplain — ADDRESS Ft Geo G Meade

231328200

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G Meade
LENGTH OF STAY (In this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George Meade, Md.
STREET ADDRESS (If rural, give location) 1906-B Patton Drive

3. NAME OF DECEASED (Type or Print): (First) Michael (Middle) Lawrence (Last) Casey
4. DATE OF DEATH: (Month) January (Day) 26 (Year) 1953

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Premature
8. DATE OF BIRTH: 26 January 53
9. AGE last birthday: yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edgar Lawrence Casey
14. MOTHER'S MAIDEN NAME: Patricia LaVerne Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT AND ADDRESS: Mother

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Congenital Atelectasis	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Prematurity	
	(c)	

762.2

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. -

19a. DATE OF OPERATION: -
19b. MAJOR FINDINGS OF OPERATION: -
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): -
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): -
(CITY OR TOWN): (COUNTY): (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour): - m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from 26 Jan, 1953, to 26 Jan, 1953, that I last saw the deceased alive on 26 Jan, 1953, and that death occurred at 0140 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Joseph B Shanahan (MD) Capt MC
ADDRESS: Fort George G Meade, Md.
DATE SIGNED: 26 Jan 53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 27 January 53
NAME OF CEMETERY OR CREMATORY: Post Cemetary
LOCATION (City, town, or county) (State): Ft Geo G Meade Md.

DATE REC'D BY LOCAL REG.: 26 Jan 53
REGISTRAR'S SIGNATURE: ARTHUR J GOMBOSH Capt MSC
24. FUNERAL DIRECTOR: HIRAM W TROSTEL, Chaplain
ADDRESS: Ft Geo Meade

2313282200

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G Meade
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G Meade
STREET ADDRESS (If rural give location) 1906-B Patton Drive

3. NAME OF DECEASED: (Type or Print) (First) Phillip (Middle) Wendell (Last) Casey
4. DATE OF DEATH: (Month) January (Day) 26 (Year) 19 53
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): remature
8. DATE OF BIRTH: 26 January 53
9. AGE last birthday: yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours 1 Min. 3
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): -
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Edgar Lawrence Casey
14. MOTHER'S MAIDEN NAME: Patricia LaVerne Young
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) -
16. SOCIAL SECURITY No.: -
17. INFORMANT & ADDRESS: Mother

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

765.2 Immediate cause (a) Congenital Atelectasis — Interval Between Onset And Death:

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Prematurity
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. -

19a. DATE OF OPERATION: -
19b. MAJOR FINDINGS OF OPERATION -
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) -
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -
(CITY OR TOWN) - (COUNTY) - (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) - m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from 26 Jan, 19.53, to 26 Jan, 19. 53, that I last saw the deceased alive on 26 Jan., 19.53, and that death occurred at 0225 am, from the causes and on the date stated above.

SIGNATURE (Degree or title) Joseph G Strahan (MD) — ADDRESS Capt MC Fort George G Meade, Md. — DATE SIGNED 26 Jan 53

23. BURIAL, CREMATION, REMOVAL (Specify) Buriel — DATE THEREOF 27 Jan 53 — NAME OF CEMETERY OR CREMATORY Post Cemetary — LOCATION (City, town, or county) (State) Fort Geo G Meade, Md.

DATE REC'D BY LOCAL REGISTRAR 26 anuary 53 — REGISTRAR'S SIGNATURE ARTHUR J COMBOS Capt MSC — 24. FUNERAL DIRECTOR HIRAM W TROSTEL Chaplain Ft Geo G Meade, Md. — ADDRESS

VS. A15

2313283200

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G Meade | LENGTH OF STAY (In this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G Meade
STREET ADDRESS (If rural, give location) 1810-F Patton Drive

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Randolph	Wilson	Christian	January	5	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	infant	5 January 53	yrs.				45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
-	-	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Eugene Joseph Christian	Jean Marie Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No -	-	Jean Marie Christian

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Congenital atelectasis	45 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Prematurity Prematurity	
	(c) Abruptio placenta Abruptio placenta	

761.1

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
-	-	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
-	-	-		

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐	Not While At work ☐	HOW DID INJURY OCCUR?
-			m.			-

22. I hereby certify that I attended the deceased from 5 January 19 53, to 5 January 19 53, that I last saw the deceased alive on 5 January, 1953, and that death occurred at 0110 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Joseph B Sheehan	Capt. M.C.	Fort George G Meade Anne Arundel Md.	6 Jan 53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	6 January 53	Post Cemetary	Fort George G Meade, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5 Jan 53	ARTHUR J. COMBOS Capt MSC	O.H. KELLY Lt Col (Chaplain)	

2132210

Bernard V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G Meade
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 4610 Garrison Blvd.

3. NAME OF DECEASED (Type or Print): (First) Peter (Middle) Carl (Last) Collins
4. DATE OF DEATH: (Month) January (Day) 17 (Year) 1953
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Infant
8. DATE OF BIRTH: 16 Jan 53
9. AGE last birthday: yrs. If under 1 year: Months Days; If under 24 hrs.: Hours 19 Min. 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Warren Lincoln Collins
14. MOTHER'S MAIDEN NAME: Geraldine Augustus Steinberger
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: *
17. INFORMANT AND ADDRESS: 804 Signal Bn. Ft Holabird (father)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Atelectasis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Prematurity (7 mos)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. -

19a. DATE OF OPERATION: -
19b. MAJOR FINDINGS OF OPERATION: -
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): -
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: -
(CITY OR TOWN) -
(COUNTY)
(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) -
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from 17 Jan, 1953, to 17 Jan, 1953, that I last saw the deceased alive on 17 Jan, 1953, and that death occurred at 1600 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Charles R Dempsey Capt MC Ft George G Meade, Md. 17 Jan 53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 20 Jan 53
NAME OF CEMETERY OR CREMATORY: Post Cemetary
LOCATION (City, town, or county) (State): Fort George G Meade, Md.

DATE REC'D BY LOCAL REG: 19 January 53
REGISTRAR'S SIGNATURE: Arthur J Comstock Capt MSC
24. FUNERAL DIRECTOR ADDRESS: B.J. FENTON, Chaplain (Lt Col) Ft Meade, Md

2012-1320

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A1 -51

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riva
LENGTH OF STAY (in this place) 4 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rivercrest Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Calvert
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Prince Frederick
STREET ADDRESS — (If rural, give location) ✓

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) McKenzie (Last) Duke

4. DATE OF DEATH: (Month) Jan (Day) 30 (Year) 19-53

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): S

8. DATE OF BIRTH: Apr. 24 1854

9. AGE last birthday: 98 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Calvert County Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James Duke

14. MOTHER'S MAIDEN NAME: Adeline Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: No

17. INFORMANT & ADDRESS: Mr Thomes Brayshaw - Glen Burnie Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Bronchopneumonia — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Senility — DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH: 7 days

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION:** **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from — , 19 49 , to 1-30 , 19 53 , that I last saw the deceased alive on 1-24 , 19 53 , and that death occurred at 11 30 A.M., from the causes and on the date stated above.

SIGNATURE Philip Brucia — (DEGREE OR TITLE) M.D. — ADDRESS 212 Prince George Bowie — DATE SIGNED 1-30-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF Feb. 2, 1953 — NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery — LOCATION (City, town, or county) (State) Prince Frederick, Md.

DATE REC'D BY LOCAL REG. 2-2-53 — REGISTRAR'S SIGNATURE H. W. Ward — **24. FUNERAL DIRECTOR** — ADDRESS C. R. Harkness & Son - Mutual, Md.

2-4-53 W. R. Clayton

Item 8 FilmG151 2/25/53 whw

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (illegible) 20

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shadyside
LENGTH OF STAY (in this place) 1
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shadyside
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Eugenia (Middle) Whitfield (Last) Dupkin

4. DATE OF DEATH: (Month) Jan (Day) 19 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 6/24/1853

9. AGE last birthday: 59 yrs. IF UNDER 1 YEAR Months 8 Days 7 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Private home

11. BIRTHPLACE (State or foreign country): Shadyside Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Whitfield Sims

14. MOTHER'S MAIDEN NAME: Caroline Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) none (If Yes, give war or dates of service) none

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Mamie Louise Johnson Shadyside Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

170X

Immediate cause (a) Metastatic Neoplasm.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Neoplasm of left breast.

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-17, 1953, to 1-19, 1953, that I last saw the deceased alive on 1-17, 1953, and that death occurred at 7 P m., from the causes and on the date stated above.

SIGNATURE Francis Grant M.D. (DEGREE OR TITLE) ADDRESS Shadyside, Md. DATE SIGNED 1-21-53.

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF Jan 23, 1953

NAME OF CEMETERY OR CREMATORY St Matthews

LOCATION (City, town, or county) (State) Shadyside Md.

DATE REC'D BY LOCAL REG. 1/24/53

REGISTRAR'S SIGNATURE H. K. Clayton

24. FUNERAL DIRECTOR ADDRESS T. A. Hardesty & Son Edgewood, Md.

VS. A15

Film G150, Item #9
1/16/53, mnb

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18[illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Tie correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 51

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 167 West Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 167 West Street

3. NAME OF DECEASED (Type or Print): (First) AUGUSTA (Middle) (Last) DUVAL

4. DATE OF DEATH: (Month) (Day) (Year) JANUARY 8, 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: June 26, 1872

9. AGE last birthday: 80 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Duval

14. MOTHER'S MAIDEN NAME: Katherine Geisel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no — (If Yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mrs. Elizabeth D. Rawlings same as #2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
422.1 Immediate cause	(a) Cerebral Hemorrhage (rt.)	1 Day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Arteriosclerosis Cerebro-Vascular Disease	14 yr.
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/1 19[illegible], to 1/8/53, 19....., that I last saw the deceased alive on 1/8/53, 19....., and that death occurred at 7:30 A.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

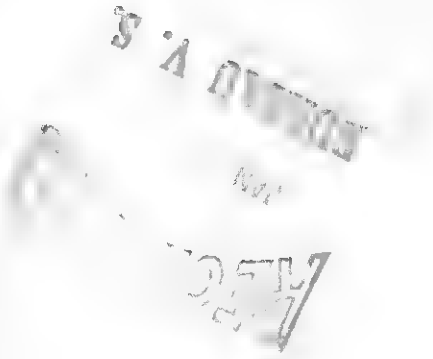
Albert R. Anderson M.D. Annapolis, Md. 1/8/53.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Jan. 10, 1953 — NAME OF CEMETERY OR CREMATORY: St. Anne's Cemetery — LOCATION (City, town, or county) (State): Annapolis, Md.

DATE REC'D BY LOCAL REG.: Jan. 9, 1953.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR — ADDRESS: Ben L. Hopping and Son Annapolis, Md.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible] 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. General

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 221 Duke of Gloucester

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
MARION	LEE	DUVAL	1	13	1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Single	March 18, 1878	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
None	none	Cumberland Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Edmund Perry Duval	Marion LEE Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
		Richard J. Duval Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Arteriosclerosis generalized	Several years.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-12, 1953, to 1-13, 1953, that I last saw the deceased alive on 1-13, 1953, and that death occurred at 11 P. m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
George Basil MD Annapolis Md 1-15-53

23. BURIAL, ~~CREMATION~~, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town or county)	(State)
	1-16-53	St Anns	Annapolis	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 15, 1953	J. C. Duval B.W.	John W. Gaylen Sons	Annapolis Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Severna Park
LENGTH OF STAY (in this place) 2 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine Crest Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY A A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaelport
STREET ADDRESS 405 President St (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) HARRY (Middle) E. (Last) FELDMEYER

4. DATE OF DEATH: (Month) January (Day) 31 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: June 4-1867

9. AGE last birthday: 85 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Truck Farm

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Gottlieb Feldmeyer

14. MOTHER'S MAIDEN NAME: Dorothea Von Oberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Sealey W. Feldmeyer Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause (a) Arteriosclerotic Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Arteriosclerosis, general

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/16, 19 53, to 1/31, 19 53, that I last saw the deceased alive on 1/16, 19 53 and that death occurred at 7 A.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Bobby L. Jones M.D. Glen Burnie Md 1/31/53

23. BURIAL, CREMATION, REMOVAL (Specify): DATE THEREOF 2-3-53 NAME OF CEMETERY OR CREMATORY St Annes LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Feb. 2, 1953

REGISTRAR'S SIGNATURE L. DeAlton

24. FUNERAL DIRECTOR John W. Sayles Sons ADDRESS Annapolis Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01062

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN: Crownsville
LENGTH OF STAY (in this place): 11½ mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: 731 Central Avenue
STREET ADDRESS (If rural, give location): Baltimore City

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) (Last) Gaskans

4. DATE OF DEATH: (Month) 1 (Day) 31 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 1891?

9. AGE last birthday: 61? yrs. — IF UNDER 1 YEAR: Months —; Days —. IF UNDER 24 HRS.: Hours —; Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) — — — —

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

443X

Immediate cause — (a) Hypertensive Cardiovascular Disease — Interval Between Onset and Death: Known to us since adm. 2/15/52

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — — — — —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — — — —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — — — — (CITY OR TOWN) — — — — — — — — — — (COUNTY) — — — — (STATE) — — — — — — — —

TIME (Month) (Day) (Year) (Hour) OF INJURY — — — — — — M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR? — — — — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 2/15/ 19 52, to 1/31 19 53 that I last saw the deceased alive on 1/31 19 53, and that death occurred at 3:20 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Jacob Ungerleider M.D. ADDRESS Crownsville, Md. DATE SIGNED 1/31/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF 2/11/53 — NAME OF CEMETERY OR CREMATORY University Med School — LOCATION (City, town, or county) ~~Baltimore~~ Balto City (State) Md

DATE REC'D BY LOCAL REG. 2/11/53 — REGISTRAR'S SIGNATURE L. J. DeAlba — 24. FUNERAL DIRECTOR Frances A Hemsley — ADDRESS 578 W Baltimore St

L. M. Joyce

RECEIVED
FEB 13 1953
U.S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town: Severna Park P.O. Md

LENGTH OF STAY (in this place): 10 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland — COUNTY Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington Ave; Odenton Md

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) CLARENCE (Middle) EDWIN (Last) GRANGER

4. DATE OF DEATH: (Month) January (Day) 20 (Year) 19 53

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: May 20 1875

9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Paper hanger

10b. KIND OF BUSINESS OR INDUSTRY: Paper ~~Hanging~~

11. BIRTHPLACE (State or foreign country): (Bur) ~~Maryland~~ Md

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Ed. W. Granger

14. MOTHER'S MAIDEN NAME: Anna L. Saunders

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: 219078673

17. INFORMANT & ADDRESS: Virginia G. Bodner - Rfd #2 - Box 376 Severna Park, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

Immediate cause (a) Congestive Heart Failure — 1 mo.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Generalized Arteriosclerosis — 3 yrs.

DUE TO (c) Senility

4-2-0

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. —

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 10/12, 1952, to 1/20, 1953, that I last saw the deceased alive on 1/19, 1953, and that death occurred at 11:15 PM from the causes and on the date stated above.

SIGNATURE (Degree or title): R. W. Pritchard M.D. — ADDRESS: Glen Burnie — DATE SIGNED: Maryland (State)

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1/23/53 — NAME OF CEMETERY OR CREMATORY: Lorraine Park Cem. — LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE REC'D BY LOCAL REGISTRAR: 1/21/53 — REGISTRAR'S SIGNATURE: A. W. Hedrick — FUNERAL DIRECTOR: Wm. J. Tschner & Sons — ADDRESS: Balto 17, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY A a. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riva
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A a.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riva
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Lillian (Middle) (Last) Griffith

4. DATE OF DEATH: (Month) 1 (Day) 31 (Year) 1953

5. SEX: F

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: Unknown

9. AGE last birthday: about 88 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT AND ADDRESS: Riva - River Side Nursing Home Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic C.V.D. — Interval Between Onset and Death: yrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/—, 1953 to 1/30, 1953 that I last saw the deceased alive on 1/30, 1953 and that death occurred at 4 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Frank M. Shipley M.D. Annapolis, 2/1/53

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 2-6-53 | NAME OF CEMETERY OR CREMATORY Baldwin Memorial | LOCATION (City, town, or county) Millersville | (State) Md

DATE REC'D BY LOCAL REG. Feb. 2, 1953 | REGISTRAR'S SIGNATURE Edward Culbreson

24. FUNERAL DIRECTOR John M. Taylor Son Annapolis Md. ADDRESS

VS. A15

FEB 13 1953

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton
LENGTH OF STAY (In this place) 91 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) ELIZABETH (Middle) (Last) GROSS

4. DATE OF DEATH: (Month) Jan (Day) 19 (Year) 1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	Colored	Widowed	Aug 23, 1861	91 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
DOMESTIC	Housekeeper	Snodyside, Md.	

13. FATHER'S NAME: John Henry Cooter — 14. MOTHER'S MAIDEN NAME: Sophia Cooter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
none	none	Cyprus Gross, Churchton, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage.	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Arteriosclerotic Vascular Disease.	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Bowie Linn Grant M.D.	Shady Side, Md.	1-21-53

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/22/53	Gross	Churchton Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/22/53	H. C. Clayton	T A Hardesty & Son	Galesville Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (illegible)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: New Jersey — COUNTY: Essex
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Irvington
STREET ADDRESS (If rural, give location): 43 Orchard Place

3. NAME OF DECEASED: (First) George (Middle) Charles (Last) HAGMANN Jr.
4. DATE OF DEATH: (Month) January (Day) 8 (Year) 1953
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 3-17-06
9. AGE last birthday: 46 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dry Cleaner
10b. KIND OF BUSINESS OR INDUSTRY: Dry Cleaners
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George Charles HAGMANN
14. MOTHER'S MAIDEN NAME: Elizabeth BENDER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes — (If Yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT & ADDRESS: Hospital Records, USNH, Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) ENCEPHALOMALACIA, Massive, left cerebral lobe (332)	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Hemorrhage of internal capsule (331)	2 days
	DUE TO (c) Rupture of lenticulostriate artery of brain (331)	2 days

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive heart disease (443) — 5 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 Jan., 19.53., to 8 Jan., 19.53., that I last saw the deceased alive on 8 Jan, 19.53, and that death occurred at 8:00 a.m., from the causes and on the date stated above.

SIGNATURE: R. M. DIMETTE, LT MC USN — (DEGREE OR TITLE) ADDRESS: U.S. Naval Hospital, Annapolis, Md. — DATE SIGNED: 1-8-53

23. BURIAL, CREMATION REMOVAL (Specify): Removal
DATE THEREOF: January 9 53
NAME OF CEMETERY OR CREMATORY: to
LOCATION (City, town, or county) (State): Newark, N.J.

DATE REC'D BY LOCAL REG.: Jan. 9, 1953
REGISTRAR'S SIGNATURE: (signature)
24. FUNERAL DIRECTOR: B.L.Hopring and Son — ADDRESS: Annapolis, Md

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Robinson Nr. Annapolis
LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Robinson Nr. Annapolis, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Robinson Nr. Annapolis, Md.
STREET ADDRESS (If rural, give location) Robinson Nr. Annapolis, Md.

3. NAME OF DECEASED (Type or Print): (First) Cathaline (Middle) W. (Last) Hall

4. DATE OF DEATH: (Month) (Day) (Year) 1/29/1953 19

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 9/5/1951

9. AGE last birthday: 16mos XXXX yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Washington A. Hall Jr.

14. MOTHER'S MAIDEN NAME: XXXXXXX Mary Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ---------

17. INFORMANT AND ADDRESS: Washington Hall-Robinson, Nr. Annapolis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Third degree Burns Entire body

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY (OR CONTRIBUTING) CAUSE OF DEATH | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home | (CITY OR TOWN) Robinson (COUNTY) Anne Arundel (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): 1 29 53 P m. | INJURY OCCURRED While at work ☑ Not while at work ☐ | HOW DID INJURY OCCUR? FIRE.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED: 1/30/53.

23. BURIAL, CREMATION OR REMOVAL (Specify): 2/1/1953 | DATE THEREOF: Burial | NAME OF CEMETERY OR CREMATORY: Magothy, Cemetery | LOCATION (City, town, or county) (State): Magothy Nr. Annapolis, Md.

DATE REC'D BY LOCAL REG.: Jan. 30, 1953 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS: William A. Jackson-916 Penn. Ave. Baltimore, Maryland

COPY SENT TO LOCAL BOARD

DATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lambrills — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lambrills.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Francis (Middle) Rebecca. (Last) Hall

4. DATE OF DEATH: (Month) Jan. (Day) 30 (Year) 1953

5. SEX: Fem. | 6. COLOR OR RACE: Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married | 8. DATE OF BIRTH: July 3 1878 | 9. AGE Last Birthday: 74 yrs. | IF UNDER 1 YEAR: Months Days | IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Domestic | 10b. KIND OF BUSINESS OR INDUSTRY: Gen. Home wife | 11. BIRTHPLACE (State or foreign country): Lambrills Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jeremiah Hall | 14. MOTHER'S MAIDEN NAME: Lenora Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No.: | 17. INFORMANT & ADDRESS: Thomas Hall Lambrills

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

420.1

Immediate cause (a) Coronary Thrombosis. — DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Acute Sclerosis — DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 17, 1942, to Jan 30, 1953, that I last saw the deceased alive on Jan 27, 1953 and that death occurred at 8.30 A.M., from the causes and on the date stated above.

SIGNATURE John Alexander Md (Degree or title) — ADDRESS Glen Burnie — DATE SIGNED 1/30/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Feb. 2 1953 | NAME OF CEMETERY OR CREMATORY Macedonia | LOCATION (City, town, or county) Lambrills (State) Md

DATE REC'D BY LOCAL REGISTRAR Jan. 31, 1953 / Feb 10 53 | REGISTRAR'S SIGNATURE K M Joyce | 24. FUNERAL DIRECTOR J. B. Johnson — ADDRESS Annapolis

VS. A15

FEB 13 1953

Item 7 Film G150 1/22/53 whw

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Deale, Md. — LENGTH OF STAY (in this place): 49 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Deale MD. — COUNTY: a a.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Deale
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Rubin (Last) Harwood (Mac)

4. DATE OF DEATH: (Month) Jan (Day) 8 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: ~~4/8~~/1893

9. AGE last birthday: 59 5/12 (yrs.) — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Master Machinist

10b. KIND OF BUSINESS OR INDUSTRY: U S Navy Dunlap

11. BIRTHPLACE (State or foreign country): Boston, Massachusetts

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Stella E. Harwood 1207 Potomac Ave Hagerstown Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) CORONARY EMBOLISM	1 hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Auricular Fibrillation	2 wk
	(c) Hypertensive CV Disease	5 yrs.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Obesity	12 yrs.

420.1

19a. DATE OF OPERATION: 1949 — 19b. MAJOR FINDINGS OF OPERATION: Chr Cholecystitis & cholelithiasis — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1942, 19..., to 8 JAN, 1953, that I last saw the deceased alive on 8 JAN, 1953, and that death occurred at 1 00 P.M., from the causes and on the date stated above.

SIGNATURE: Robert B. Carson (Degree or title) MD ADDRESS: Upper Marlboro Md DATE SIGNED: 8 Jan 53.

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Jan 10, 1953 — NAME OF CEMETERY OR CREMATORY: Woodfield — LOCATION (City, town, or county) (State): Galesville Md.

DATE REC'D BY LOCAL REG.: 1/10/53 — REGISTRAR'S SIGNATURE: J.M. Crayton

24. FUNERAL DIRECTOR: T A Hardesty & Son — ADDRESS: Galesville Md

VS. A15

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS State Reformatory for Women

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) None

3. NAME OF DECEASED (Type or Print): (First) Roberta (Middle) — (Last) Heldoth
4. DATE OF DEATH: (Month) Jany (Day) 26 (Year) 1953
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH:
9. AGE last birthday: 34 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: (Not Known) Mitchell
14. MOTHER'S MAIDEN NAME: Lilly Mitchell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: Institution Records Jessup

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coma — several

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cirrhosis of liver — months

581.1 (5121)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. alcoholism

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 16, 1953, to Jan 26, 1953, that I last saw the deceased alive on Jan 25, 1953 and that death occurred at 305 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John A Clark MD, Jessup Md Jany 26 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Removal | DATE THEREOF: 1/26/53 | NAME OF CEMETERY OR CREMATORY: University Med School | LOCATION (City, town, or county): Balto County | (State): Md

DATE REC'D BY LOCAL REG.: Jan 26-53 | REGISTRAR'S SIGNATURE: Clara Baslup

24. FUNERAL DIRECTOR: Frances J Hemsley | ADDRESS: 5 to W Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN P.O. Glen Burnie
LENGTH OF STAY (in this place) 2 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Marley Neck Road.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]
STREET ADDRESS (If rural give location) [illegible]

3. NAME OF DECEASED: (Type or Print) (First) Josephine (Middle) Elizabeth (Last) Holland

4. DATE OF DEATH: (Month) Jan. (Day) 1st (Year) 1953

5. SEX: F.

6. COLOR OR RACE? Colored.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed.

8. DATE OF BIRTH: 11/5/89

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hardys, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Georges Holland

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mrs. Boyd Woods. (daughter.)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary thrombosis of right heart. — Interval Between Onset And Death: 4 years.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b)

(c)

170

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None. 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) No

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October, 1952, to Jan. 1, 1953, that I last saw the deceased alive on 2/23, 1952, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Senator Hardesty — ADDRESS Glen Burnie Md. — DATE SIGNED Jan. 1st 1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1-6-53 — NAME OF CEMETERY OR CREMATORY Mt Olivet Cem. — LOCATION (City, Town, or county) (State) Brooklyn Md

DATE REC'D BY LOCAL REGISTRAR 1/5/53 — REGISTRAR'S SIGNATURE [illegible] — 24. FUNERAL DIRECTOR Elroy D. Wilson — ADDRESS 1020 Brantley Ave

Dr

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 323 Adams St

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 323 Adams St

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) E. (Last) Holland

4. DATE OF DEATH: (Month) 1 (Day) 15 (Year) 1953

5. SEX: F

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH: 8-7-1857

9. AGE last birthday: 95 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): New Town Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Burton

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) —
(If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Luster R. Holland Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

450.0

Immediate cause (a) General Arteriosclerosis & Senility

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Senile psychosis.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION?

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1, 1940, to 1/15, 1953, that I last saw the deceased alive on 1/15, 1953, and that death occurred at ... m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Maurice Klemans, MD ADDRESS Annapolis, Md DATE SIGNED 1/17/53

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify): DATE THEREOF 1-17-53 NAME OF CEMETERY OR CREMATORY Cedar Bluff LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. 1/17/53 REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR John W. Taylor & Sons ADDRESS Annapolis Md

VS. A15 51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 0[illegible]128

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 2 yrs. 11 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville, State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Kent
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Chestertown, Maryland
STREET ADDRESS (If rural give location): Unknown ✓

3. NAME OF DECEASED: (Type or Print) (First) Maggie (Middle) (Last) Holley

4. DATE OF DEATH: (Month) 1 (Day) 11 (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1916?

9. AGE last birthday: 36? yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Louis Holley

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) — — —

16. SOCIAL SECURITY No.: — — — —

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

Immediate cause (a) General Paresis — Known to us since adm. 1/11/53

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — — — —

19b. MAJOR FINDINGS OF OPERATION — — — —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — — — —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — — —

(CITY OR TOWN) (COUNTY) (STATE) — — — —

TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? — — — —

22. I hereby certify that I attended the deceased from 2/2 19 50, to 1/11, 19 53, that I last saw the deceased alive on 1/11, 19 53, and that death occurred at 5:55 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jacob Mongesterm M.D.
ADDRESS: Crownsville, Md.
DATE SIGNED: 1/11/53

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) — DATE THEREOF: 1/16/53 — NAME OF CEMETERY OR CREMATORY: Crownsville State Hospital — LOCATION (City, town, or county) (State): Crownsville, Md.

DATE REC'D BY LOCAL REGISTRAR: 1-16-53 — REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR — ADDRESS: Jacob Mongesterm M.D. Crownsville Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie
MARYLAND LENGTH OF STAY (in this place): 46 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 510 Fifth Ave.S.E.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Same COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Same
STREET ADDRESS (If rural give location): Same

3. NAME OF DECEASED: (First) Mary (Middle) C. (Last) Hosse
4. DATE OF DEATH: (Month) Jan.4th (Day) (Year) 1953

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: I/27/79
9. AGE Last birthday: 73 yrs. IF UNDER 1 YEAR Month Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Troy, New York.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Butler
14. MOTHER'S MAIDEN NAME: ? O'Leary

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): NO
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Ernest Hosse, (Husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) DUE TO: Cerebral Hemorrhage — Interval Between Onset And Death: 2 hrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO: Hypertension — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan.4th-53 to I/4/53, 19, that I last saw the deceased alive on I/4/53 19, and that death occurred at 2.15 A.M., from the causes and on the date stated above.

SIGNATURE: Gustave A Rumbaugh (Degree or title) ADDRESS: Glen Burnie, Md. DATE SIGNED: I/4/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 1/6/53
NAME OF CEMETERY OR CREMATORY: Glen Haven
LOCATION (City, town, or county) (State): Glen Burnie, Md.

DATE REC'D BY LOCAL REGISTRAR: 1/5/53
REGISTRAR'S SIGNATURE: L. J. DeLeon
24. FUNERAL DIRECTOR: P V Singleton ADDRESS: Glen Burnie, Md.

RECEIVED
JAN 7 1
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 12 Tarole St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 12 Tarole St

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) D (Last) Isaacs

4. DATE OF DEATH: (Month) 1 (Day) 25 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: 12-6-1889

9. AGE last birthday: 63 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Building attendant

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Naval Academy

11. BIRTHPLACE (State or foreign country): Lothian Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charlie Isaacs

14. MOTHER'S MAIDEN NAME: Elsie Owens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Hazel Brooks - Annapolis, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cirrhosis of Liver, Primary — INTERVAL BETWEEN ONSET AND DEATH: July 1952

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) [illegible] 58

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 59, to Jan 25, 53, that I last saw the deceased alive on Jan 25, 53, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

SIGNATURE R. R. Gardner (Degree or title) M.D. ADDRESS Ann. Md. DATE SIGNED 1/26/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 1-28-1953

NAME OF CEMETERY OR CREMATORY: John Wesley

LOCATION (City, town, or county) (State): Annapolis Neck, Md.

DATE REC'D BY LOCAL REG. 1/27/53

REGISTRAR'S SIGNATURE: A. N. Hedrick M.D.

24. FUNERAL DIRECTOR: William Reese II

ADDRESS: 108 W. Washington St. Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY AA Co. Severna Park MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | LENGTH OF STAY (In this place) Life time
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R2. Severna Park
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William	Nimrod	Jennings	JAN.	10	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	Colored	Married	June 7 1870	82 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming	Farm Owner	Severna Park, Md.	U.S.A.

13. FATHER'S NAME: Thomas H. Jennings

14. MOTHER'S MAIDEN NAME: Georgeanna Dotson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary thrombosis	5 yrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

42c 1

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from June 1952, to Jan 10, 1953, that I last saw the deceased alive on Jan 10, 1953, and that death occurred at 4 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
M K Jolliffe		Severna Park Md	1-14-53

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 13, 1953	Town Neck	Severna Park Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 12, 1953	[signature]	J.B. Johnson	Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 318 Chester Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 318 Chester Ave

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Edward (Last) Johnson
4. DATE OF DEATH: (Month) 1 (Day) 29 (Year) 1953

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 27 1888
9. AGE last birthday: 64 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Minister
11. BIRTHPLACE (State or foreign country): Annapolis Md
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: David Johnson
14. MOTHER'S MAIDEN NAME: Emily Tromis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-05-2436
17. INFORMANT AND ADDRESS: Florence Johnson Annapolis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Pulmonary Edema	1 hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Bronchopneumonia	3 days.
	(c) Bronchial Asthma	30 yrs.

241X (493X)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Peptic Ulcer

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/28, 1953, to 1/29/, 1953, that I last saw the deceased alive on 1/29, 1953, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Frank M. Shipley, M.D. Annapolis, 1/31/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Feb 1 1953
NAME OF CEMETERY OR CREMATORY Brewer Hill
LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Jan. 31, 1953
REGISTRAR'S SIGNATURE B.W.
24. FUNERAL DIRECTOR D. E. Johnson
ADDRESS Annapolis

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M. H. General Hosp.

1. PLACE OF DEATH: COUNTY Anne Arundle MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundle General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Anne Arundle COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.; STREET ADDRESS (If rural, give location) Bunche St.

3. NAME OF DECEASED (Type or Print): (First) Gyrvin (Middle) (Last) Johnson

4. DATE OF DEATH: (Month) 1 (Day) 13 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: 7-17-1887

9. AGE last birthday: 65 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Md Hotel

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Will ...

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-05-1060

17. INFORMANT AND ADDRESS: George Johnson 82 Washington St Annapolis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pneumonia	2 Mon
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Bronchiectiasis	2 + mos
	(c) Bronchogenic Carcinoma	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Treacheoesophageal fistulae — 2 + mos

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/13/53, to 1/13/53, that I last saw the deceased alive on 1/13/53, and that death occurred at 9 P.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank M. Shipley	M.D.	Annapolis,	1/15/53

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-16-53	Brewer Hill	Annapolis Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 16, 1953	[signature] D.R.	William Reese & Son	107 W. Washington St Annapolis, Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel. LENGTH OF STAY (In this place) 7 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS District Training School

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington COUNTY D. C
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington D. C
STREET ADDRESS (If rural, give location) 830 - 3rd. St. N. W

3. NAME OF DECEASED (Type or Print): (First) Joan (Middle) NONE (Last) Johnson
4. DATE OF DEATH: (Month) 1 (Day) 7 (Year) 1953
5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 3-3-1941
9. AGE last birthday: 11 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Garfield - Johnson
14. MOTHER'S MAIDEN NAME: Elizabeth Mc. Bath.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NE
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT AND ADDRESS: D.T.S. Records. Laurel. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Broncho - Pneumonia - Bilateral	4 D.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Congenital Malformation. Spastic -	life
	(c) Organic Mental Disease	Life

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Amendat my.

19a. DATE OF OPERATION: NONE
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-26, 1952, to 1-7-, 1953, that I last saw the deceased alive on 1-7-, 1953, and that death occurred at 11:04 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
B. Stenduf. M.D. Medical Officer Laurel. Md. 1/7/1953.

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF: Jan 10-53 NAME OF CEMETERY OR CREMATORY: Washington LOCATION (City, town, or county) (State): D C

DATE REC'D BY LOCAL REG.: Jan 8-53 REGISTRAR'S SIGNATURE: Clara Coakley
24. FUNERAL DIRECTOR: Ella Louise Stephens ADDRESS: 1435 Md Ave NE

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY A. A. Co. — MARYLAND — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (In this place) ~~Life~~ 0.0.1. — HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel Gen'l. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elvaton — Pasadena P.O. — STREET ADDRESS (If rural, give location) Woods Road - Box 149

3. NAME OF DECEASED (Type or Print): (First) John. (Middle) (I...) Johnson, Sr.

4. DATE OF DEATH: (Month) 1 (Day) 10 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.

8. DATE OF BIRTH: Sept. 15 1880

9. AGE last birthday: 72 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Laborer (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Johnson Const. Co.

11. BIRTHPLACE (State or foreign country): Elvaton, A.A. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Rezin Johnson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT AND ADDRESS: Mrs. Pearl O. Johnson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Disease — Interval between onset and death: hours.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis generalized.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home — (CITY OR TOWN) Elvaton — (COUNTY) A.A.Co. — (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: C. Lee Ladd. — (Degree or title) MD — ADDRESS: Annapolis Maryland — DATE SIGNED: 1-10-53.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1-14-53 — NAME OF CEMETERY OR CREMATORY: Cedar Hill — LOCATION (City, town, or county) (State): Brooklyn R.F.D., Md.

DATE REC'D BY LOCAL REG. 1/14/1953 — REGISTRAR'S SIGNATURE: [illegible] — 24. FUNERAL DIRECTOR: R. V. Singleton — ADDRESS: Glen Burnie, Md.

FILED UNDER: JONES

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18[illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 31 yrs. 9mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: Baltimore City
STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) 1833 Jefferson St., ✓

3. NAME OF DECEASED: (Type or Print) (First) Harvey (Middle) STEWART (Last) JONES Jones
4. DATE OF DEATH: (Month) 1 (Day) 27 (Year) 19 53

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 4/29/1898
9. AGE last birthday: 54 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John H. Jones
14. MOTHER'S MAIDEN NAME: Estella Stewart

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) — —
16. SOCIAL SECURITY No.: — — — — —
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized Arteriosclerosis — Interval Between Onset And Death: Known to us since 1948
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — — — —
19b. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — — — — — —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — — — —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — — — — —
(CITY OR TOWN) (COUNTY) (STATE) — — — — — — — — — — — —
TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — — m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? — — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 10/13 ....,19 41., to 1/27/ , 19 53.., that I last saw the deceased alive on 1/27 ...., 19 53, and that death occurred at 1:30 a.m. , from the causes and on the date stated above.

SIGNATURE (Degree or title) Jack Thompson M.D. ADDRESS Crownsville, Md. DATE SIGNED 1/27/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1/31/53 — NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park — LOCATION (City, town, or county) Balto. — (State) Md.

DATE REC'D BY LOCAL REGISTRAR 1/30/53 — REGISTRAR'S SIGNATURE A.C. Redmond Dpty. — 24. FUNERAL DIRECTOR Robert H. Young — ADDRESS 1216 E. Caroline St.

VS. A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 1205 President St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis,
STREET ADDRESS (If rural, give location): 1205 President St.

3. NAME OF DECEASED: (Type or Print) (First) ELIZABETH (Middle) MAY (Last) KELSO

4. DATE OF DEATH: (Month) JANUARY (Day) 14, (Year) 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: May 14, 1896

9. AGE Last birthday: 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Philadelphia, Pa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Kelso

14. MOTHER'S MAIDEN NAME: Elizabeth Bates

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service) no

16. SOCIAL SECURITY No.: unknonw

17. INFORMANT & ADDRESS: R.M. McCaffrey same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause — (a) DUE TO: Decompensation of the heart — Interval: Immediate

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) DUE TO: Arteriosclerotic Cardio-Vascular — Interval: 2 yrs

(c) DUE TO: Pneumonia

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-7-52, 19..., to 1-14-53, 19..., that I last saw the deceased alive on ..., 19..., and that death occurred at ...m. from the causes and on the date stated above.

SIGNATURE: Allen Anderson (DEGREE OR TITLE) MD ADDRESS: Annapolis Md DATE SIGNED: 1/14/53

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE THEREOF: 1-16-53 — NAME OF CEMETERY OR CREMATORY: to — LOCATION (City, town, or county) (State): Philadelphia, Pa.

DATE REC'D BY LOCAL REG.: Jan. 14, 1953 — REGISTRAR'S SIGNATURE: J. [illegible] Branch R.G.

24. FUNERAL DIRECTOR ADDRESS: Ben L. Hopping and Son Annapolis, Md.

VS. A15 1

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 1

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Annapolis
LENGTH OF STAY (in this place) 6 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 45 Cornhill Street

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Henry (Last) KERCHNER

4. DATE OF DEATH: (Month) January (Day) 5 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: July 15, 1900

9. AGE last birthday: 52 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LTJG USN (Ret)

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Clark KERCHNER

14. MOTHER'S MAIDEN NAME: Leona LEWIS (Deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WWII

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Hospital records, USNH, Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause (a)	INFARCTION, MASSIVE, OF MYOCARDIUM #420.1	5 days
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)	CORONARY ARTERY SCLEROSIS WITH OCCLUSION, LEFT #420.1	5 days
DUE TO		
(c)	GENERALIZED ARTERIOSCLEROSIS #450	15 yrs plus

420.1

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5 Jan, 1953, to 5 Jan, 1953, that I last saw the deceased alive on 5 Jan, 1953, and that death occurred at 8:25 p.m., from the causes and on the date stated above.

SIGNATURE John E. Flynn (DEGREE OR TITLE) John E. FLYNN, LTJG MC USNR ADDRESS U.S. Naval Hospital, Annapolis, Md. DATE SIGNED 1-6-53

23. BURIAL, CREMATION REMOVAL (Specify): DATE THEREOF 1/8/53 NAME OF CEMETERY OR CREMATORY Annapolis National LOCATION (City, town, or county) (State) Annapolis, Md.

DATE REC'D BY LOCAL REG. Jan. 7, 1953 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor & Son ADDRESS Annapolis, Md.

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 1

1. PLACE OF DEATH:
COUNTY A. A. | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum | LENGTH OF STAY (in this place) 38 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS #1 Kingbrook Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights
STREET ADDRESS (If rural, give location) 12 King Brook Road

3. NAME OF DECEASED: (Type or Print) (First) Martha (Middle) Estell (Last) King.

4. DATE OF DEATH: (Month) Jan (Day) 14 (Year) 1953

5. SEX: F

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH: Nov 29 1879

9. AGE last birthday: 73 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Chas. Agustus Carpack

14. MOTHER'S MAIDEN NAME: Emma Pierson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Chas. King - (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Haemorrhage	12 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Arthritis Sclerosis - Hypertension	4 yrs
	DUE TO (c)	

331

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | **19b. MAJOR FINDINGS OF OPERATION:** | **20. AUTOPSY?** Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. | **INJURY OCCURRED** While at work ☐ Not while at work ☐ | **HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from Dec....., 1952, to 1/14....., 1953., that I last saw the deceased alive on 1/14....., 1953, and that death occurred at 10:48 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Chas. L. Ball Jr. | ADDRESS Linthicum Md | DATE SIGNED 1/14/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial | **DATE THEREOF** 1/17/53 | **NAME OF CEMETERY OR CREMATORY** Green Mount Cemetery | **LOCATION** (City, town, or county) Baltimore, (State) Maryland

DATE REC'D BY LOCAL REG. 1/16/53 | **REGISTRAR'S SIGNATURE** D.W. Hedrick DNK

24. FUNERAL DIRECTOR Wm. Cook Inc | **ADDRESS** 1217 St. Paul Street

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 11

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN: Annapolis
LENGTH OF STAY (in this place): 21 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): Pine On The Severn

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) (Last) KIRWAN

4. DATE OF DEATH: (Month) JANUARY (Day) 1 (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 11-17-90

9. AGE last birthday: 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ralph Middleton

14. MOTHER'S MAIDEN NAME: Catherine Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No — (If Yes, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Hospital Records, USNH, Annapolis, Maryland.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Congestive Heart Failure 434.1	3 Months
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Rheumatic Heart Disease, Chronic, Inactive. 416	20 Years
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, Generalized. 450.0 — 10 Years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11 DEC., 19 52, to 1 JAN., 19 53, that I last saw the deceased alive on 1 JAN., 19 53, and that death occurred at 12:30 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS: Robert W. DIMMETTE, LT.MC.USN, U.S. Naval Hospital, Annapolis, Md. — DATE SIGNED: 1-1-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 1-4-53 — NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery — LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Jan. 2, 1953 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR ADDRESS: Ben L. Hopping and Son Annapolis, Md

RECEIVED
JAN 7 1
BUREAU V. S.

Item 9 FilmG150 2/4/53 whw

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18[illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1 PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 2 yrs. 4 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
STREET ADDRESS (If rural give location): 324 N. Pine Street

3. NAME OF DECEASED: (Type or Print) (First) Martha (Middle) (Last) Knight

4. DATE OF DEATH: (Month) 1 (Day) 26 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 3/1/79

9. AGE last birthday: 73 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: ~~Unknown~~ Robert Knight

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Clara ?

15 WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY No.: Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis — Interval Between Onset And Death: Known to us since adm. 9/23/50

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

4.12.2

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/23, 1950, to 1/26, 1953, that I last saw the deceased alive on 1/26, 1953, and that death occurred at 2:50 a.m. from the causes and on the date stated above.

SIGNATURE: [illegible] (Degree or title) — ADDRESS: Crownsville Md. — DATE SIGNED: 1/26/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1/31/53 — NAME OF CEMETERY OR CREMATORY: W.M. Auburn Cem. — LOCATION (City, town, or county) (State): Balto. Md.

DATE RECD BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR

24. FUNERAL DIRECTOR: Mrs. Katie R. Williams — ADDRESS: 322 N. Schroeder St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville, Md.
LENGTH OF STAY (in this place): 4 yrs. 9mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: 11 Baltimore City
STREET ADDRESS (If rural give location): 11 Druid Hill Avenue ✓

3. NAME OF DECEASED: (First) Sarah (Middle) (Last) Kyle
4. DATE OF DEATH: (Month) 1 (Day) 16 (Year) 19 53

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH: 1878?
9. AGE last birthday: 75? yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William Minor Colban
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: — — — —
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450 0

Immediate cause (a) Generalized Arteriosclerosis — Interval Between Onset And Death: Known to us since adm. 4/9/48

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — — — —
19b. MAJOR FINDINGS OF OPERATION — — — —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — — — —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — — —
(CITY OR TOWN) (COUNTY) (STATE) — — — —
TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? — — — —

22. I hereby certify that I attended the deceased from 4/9, 1948, to 1/16, 1953, that I last saw the deceased alive on 1/16, 1953 and that death occurred at 7:25 a.m. from the causes and on the date stated above.

SIGNATURE: Jacob Hoffmeister M.D.
(Degree or title)
ADDRESS: Crownsville, Md.
DATE SIGNED: 1/16/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Jan. 18, 1953
NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Pk.
LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE REC'D BY LOCAL REGISTRAR: January 17 1953.
REGISTRAR'S SIGNATURE: R.W.

24. FUNERAL DIRECTOR: Maryland Funeral Service
ADDRESS: 1631 Druid Hill Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A.A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) The Ambassador ✓

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) H. (Last) LEMMEL
4. DATE OF DEATH: (Month) 1 (Day) 29 (Year) 1953
5. SEX: M.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married.
8. DATE OF BIRTH: Nov. 15, 1896
9. AGE last birthday: 56 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. of Public Instruction
10b. KIND OF BUSINESS OR INDUSTRY: Balto. Schools
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Lemmel
14. MOTHER'S MAIDEN NAME: Emma Ulrick
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): none (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: Mrs. Pansy K. Lemmel-The Ambassador Apts.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary-disease — Interval between onset and death:

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY State-House (CITY OR TOWN) Annapolis (COUNTY) A.A. Co. (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ✓ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: C. Lee Lucas (Degree or title) MD ADDRESS Annapolis Maryland DATE SIGNED 1.29.53.

23. BURIAL, CREMATION, REMOVAL (Specify): Removal | DATE THEREOF: 2/2/53 | NAME OF CEMETERY OR CREMATORY: Lakeside M. E. Cem. | LOCATION (City, town, or county) (State): Dover, Del.

DATE REC'D BY LOCAL REG. 2/2/53 | REGISTRAR'S SIGNATURE: A. W. Hedrick | 24. FUNERAL DIRECTOR: Wm. J. Tuckner & Sons ADDRESS: Balto. 17, Md.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH INFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edenton; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Nat'l. Plastics Co.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Prince George; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyattsville (Adm. University Park, Md.); STREET ADDRESS (If rural, give location) 4306 Sheridan St

3. NAME OF DECEASED (Type or Print): (First) Blair; (Middle) Kelsey; (Last) Lineberry

4. DATE OF DEATH: (Month) January; (Day) 23; (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 4 1907

9. AGE last birthday: 45 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sub-F. Construction

10b. KIND OF BUSINESS OR INDUSTRY: Automatic Fire Protection

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel C. Lineberry

14. MOTHER'S MAIDEN NAME: Minnie O. Ott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY No. 182 67 1986

17. INFORMANT: Mary M. Lineberry Hyattsville R.F.D. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1120.1 Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: Sudden.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) Gustave A. Lamberth D. Dental Examiner ADDRESS Glen Burnie Md. DATE SIGNED 1/25/53

23. BURIAL, CREMATION REMOVAL (Specify) Transportation; DATE THEREOF 1/25/53; NAME OF CEMETERY OR CREMATORY Muncy; LOCATION (City, town, or county) Pennsylvania (State)

DATE REC'D BY LOCAL REG. 1/25/53; REGISTRAR'S SIGNATURE Amanda Downey; 24. FUNERAL DIRECTOR F. Gaeche & Son (ADDRESS) Hyattsville Md

2-4-53 ← Clara Hodges - cmc

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 1

1. PLACE OF DEATH:
COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. G. General

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Tiverton Heights
STREET ADDRESS (If rural, give location) Annapolis

3. NAME OF DECEASED: (Type or Print) (First) Hester (Middle) Johnson (Last) Markli

4. DATE OF DEATH: (Month) 1 (Day) 30 (Year) 1953

5. SEX: F.

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH: June 11th 1877

9. AGE last birthday: 75 yrs.
IF UNDER 1 YEAR — Months / Days; IF UNDER 24 HRS. — Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home

10b. KIND OF BUSINESS OR INDUSTRY: House wife

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Johnson

14. MOTHER'S MAIDEN NAME: Marcella Gibson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Mrs Nancy Krantos Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
420.0 Immediate cause	(a) Arteriosclerotic Heart Disease	2 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Generalized Arteriosclerosis	2 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1952, to Jan 30, 1953, that I last saw the deceased alive on Jan 30, 1953, and that death occurred at 6 P. M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Kenneth C. Brice M.D. Annapolis Annapolis 1-31-53

23. BURIAL, CREMATION, REMOVAL (Specify): DATE THEREOF 2-3-53 NAME OF CEMETERY OR CREMATORY St Agnes LOCATION (City, town or county) Glen Burnie (State) Md

DATE REC'D BY LOCAL REG. Feb. 2, 1953

REGISTRAR'S SIGNATURE J. [illegible] Darnall

24. FUNERAL DIRECTOR John W. Taylor Sons ADDRESS Annapolis Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 1

1. PLACE OF DEATH:

COUNTY AA — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN 1207 West St

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Annapolis, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Conn. COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ridgefield

STREET ADDRESS (If rural, give location) 16 Main St. ✓

3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
	William		Miller	Jan	1	19 53

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
M	W		Mar 3 1886	66 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Investment Broker	Broker	New York City	U.S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
William Miller	Clara Wallace

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
—	—	Edith V. Miller Ridgefield, Conn

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause (a)	Coronary occlusion	5 min.
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)	Arteriosclerotic Heart Disease	3 yrs.
DUE TO		
(c)		

420.0

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-4-, 1953, to 1-4-, 1953, that I last saw the deceased alive on 1-4-, 1953, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

SIGNATURE James R. Swartz (DEGREE OR TITLE) M.D. ADDRESS Annapolis, Md. DATE SIGNED 1-4-53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-7-53	Evergreen	Ridgefield Conn.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 4 1953	[signature]	John H. Taylor Sons	Annapolis, Md.

RECEIVED
JAN 7
BUREAU V. S.

Item 7 Film 0150 1/23/53 whw

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 51

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): Mt. Zion
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Lothian P.O.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md COUNTY: A-A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt Zion
STREET ADDRESS (If rural, give location): Lothian Post Office

3. NAME OF DECEASED: (First) WALLACE (Middle) BENJAMIN MORELAND (Last)

4. DATE OF DEATH: (Month) 1-15- (Day) 53 (Year) 19

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower

8. DATE OF BIRTH: JAN. 13, 1870

9. AGE last birthday: 83 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TABACCO FARMER

10b. KIND OF BUSINESS OR INDUSTRY: TENNIM FARM

11. BIRTHPLACE (State or foreign country): A.A.Co. MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unkn

14. MOTHER'S MAIDEN NAME: unkn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Thomas E. Moreland Same as # 2.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 420.1

Immediate cause (a) Coronary Thrombosis

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) general arteriosclerotic vascular disease

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-14, 1953, to 1-15, 1953, that I last saw the deceased alive on 1-15, 1953, and that death occurred at 8:40 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Emily H. Wilson M.D. Lothian, Md. 1-15-53

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL

DATE THEREOF 1-18-53

NAME OF CEMETERY OR CREMATORY: MT ZION CEMETERY

LOCATION (City, town, or county) (State): LOTHIAN, MARYLAND.

DATE REC'D BY LOCAL REG. 1/16/53

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS: B.L. Hopkins & Son ANNAPOLIS, MD.

Item 9 FilmG150 1/23/53 whw

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (1952)

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Crownsville
LENGTH OF STAY (in this place) 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Dorchester
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cokesbury
STREET ADDRESS (If rural give location) R. F. D. #3

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Francis (Last) Nichols

4. DATE OF DEATH: (Month) 1 (Day) 12 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: 6/15/66?

9. AGE last birthday: 86 ~~87~~? yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Day Laborer ~~Unknown~~ farm

10b. KIND OF BUSINESS OR INDUSTRY: ~~Unknown~~ farm

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk.
(If Yes, give war or dates of service) — — — —

16. SOCIAL SECURITY NO.: — — — — —

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0
Immediate cause (a) Generalized Arteriosclerosis — Interval Between Onset And Death: Known to us since adm. 12/24/52

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — — — — — —

19b. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — — — — — — — —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — — — —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — — — — — — —

(CITY OR TOWN) — — — — — — — — — — — — — — — — — —

(COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — — m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? — — — — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 12/24, 1952, to 1/12, 1953, that I last saw the deceased alive on 1/12, 1953, and that death occurred at .., from the causes and on the date stated above.

SIGNATURE (Degree or title) Jacob Hagerstown M.D.

ADDRESS Crownsville, Md.

DATE SIGNED 1/12/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 1/15-53

NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery Md.

LOCATION (City, town, or county) (State) Cokesbury Md

DATE REC'D BY LOCAL REGISTRAR Jan. 12, 1953

REGISTRAR'S SIGNATURE K. M. Jones

24. FUNERAL DIRECTOR J J Frampton Son

ADDRESS Federalsburg Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 1

1. PLACE OF DEATH:
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: ~~Baltimore~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 3029 Arunah Avenue

3. NAME OF DECEASED (Type or Print): (First) Adam (Middle) (none) (Last) OHLE

4. DATE OF DEATH: (Month) January (Day) 10 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 2, 1885

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boatswain Mate

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Name unknown (Deceased)

14. MOTHER'S MAIDEN NAME: Name unknown (Deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WWI

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT & ADDRESS: Hospital records - USNH, Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 420.1

		Interval Between Onset and Death
Immediate cause	(a) INFARCTION OF MYOCARDIUM, LEFT VENTRICLE, EXTENSIVE	10 days
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) CORONARY ARTERY OCCLUSION 420.1	10 days
DUE TO		
	(c) ARTERIOSCLEROTIC HEART DISEASE 420.0	5 years plus

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. HEMORRHAGIC PANCREATITIS 587.0 — 18 hours

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [X] No [ ]

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M. — INJURY OCCURRED While at work [ ] Not while at work [ ] — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10 Jan, 19 53, to 10 Jan, 19 53, that I last saw the deceased alive on 10 Jan, 19 53, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

SIGNATURE: R. K. Moxon — (DEGREE OR TITLE): LCDR (MC) USN — ADDRESS: U.S. Naval Hospital Annapolis, Md. — DATE SIGNED: 1-10-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 1/14/53 — NAME OF CEMETERY OR CREMATORY: Western Cemetery — LOCATION (City, town, or County) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REG. 1/13/53 — REGISTRAR'S SIGNATURE: W. Redrick — **24. FUNERAL DIRECTOR** Joseph F. Cimbure — ADDRESS: 1328 Sulphur Spring Rd.

DEER

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY A. A. Co. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Beale | MARYLAND | LENGTH OF STAY (In this place) | HOSPITAL OR INSTITUTION OR STREET ADDRESS ?

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland | COUNTY A. A. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Edward	Franklin	O'Neal	Jan.	26	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White		Mar. 25	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waterman		Baltimore	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Oneal	Sarah B. Evans

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
		Wilson Phippse

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) Coronary disease	
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized arteriosclerosis	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home	(CITY OR TOWN) Beale	(COUNTY) A.A.	(STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour)	m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Thos Leach	MD	Annapolis Md	1/28/53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/28/53	St. James Cem	Beale Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/28/53	H. R. Clayton	J. A. Hardesty & Sons	

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park, Brooklyn — LENGTH OF STAY (in this place) + 16 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 121 - Bisby ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Wesley (Last) Patterson

4. DATE OF DEATH: (Month) June (Day) 23 (Year) 1953

5. SEX: M. | 6. COLOR OR RACE: Colored. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed | 8. DATE OF BIRTH: ? | 9. AGE last birthday: 82 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer. | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Buckingham County, Va. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wesley Patterson | 14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: ? | 17. INFORMANT AND ADDRESS: Isaac Pat[illegible] Anne

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450

Immediate cause (a) Arteris - sclerotic Vascular

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) disease. — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION — | 19b. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. — | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY — m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED

Gustave A. Faulenbach M.D. Deputy Medical Examiner. Crownsville, Md. 1/23/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Jan 27th | NAME OF CEMETERY OR CREMATORY: Mt Calvary | LOCATION (City, town, or county): A A Co. | (State)

DATE REC'D BY LOCAL REG. 1/29/54 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR: Albury & Wilson | ADDRESS: 1000 Brantley

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 5-3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 51

1. PLACE OF DEATH:
COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LINTHICUM HEIGHTS
LENGTH OF STAY (in this place) 5 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS HAMMOND'S FERRY ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Anne Arundle
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights
STREET ADDRESS (If rural, give location) Hammond's Ferry Rd.

3. NAME OF DECEASED: (Type or Print) (First) HETTIE (Middle) (Last) PETERSON

4. DATE OF DEATH: (Month) Jan. (Day) 31 (Year) 1953

5. SEX: F

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Jan. 26-1872

9. AGE last birthday: 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Waldman

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Walter Johnson 1609 Llewellyn St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

260X

Immediate cause (a) Diabetes Mellitus — Interval between onset and death: 20 yrs

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) Chronic Nephritis — 5 mo +

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 6, 1952, to Jan 31, 1953, that I last saw the deceased alive on Jan 29, 1953, and that death occurred at 12 Midnight, from the causes and on the date stated above.

SIGNATURE C. Milton Linthicum (DEGREE OR TITLE) M.D. ADDRESS Linthicum Heights Rd. DATE SIGNED Jan 31, 1953

23. BURIAL, CREMATION / REMOVAL (Specify): Burial

DATE THEREOF Jan. 3-1953

NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk. Cem.

LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REG. 2/2/53

REGISTRAR'S SIGNATURE A. L. Broderick

24. FUNERAL DIRECTOR John A. Miller ADDRESS 2334 Jefferson St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Homewood Convl. Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): 8 Revell Street

3. NAME OF DECEASED: (First) LILA (Middle) CLAUDE (Last) PEYTON (Type or Print)

4. DATE OF DEATH: (Month) January (Day) 4, (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: March 7, 1885

9. AGE last birthday: 67 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: House wife

10b. KIND OF BUSINESS OR INDUSTRY: own Home

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Washington Clement Claude

14. MOTHER'S MAIDEN NAME: Fanny Wilkinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mrs Walton R. Pead Sister, Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause	(a) Carcinoma Rt Eye, metastasis	6 Months
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO Lt Brain	
	(c) DUE TO Arteriosclerosis generalized	Several years

192+

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Lept Hemiplegia — 2 weeks

19a. DATE OF OPERATION: — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1 ..., 1952, to Jan 4 ., 1953, that I last saw the deceased alive on Jan 3. , 1953., and that death occurred at 7 AM, from the causes and on the date stated above.

SIGNATURE: George C Boarman — (Degree or title) MD — ADDRESS: Annapolis Md — DATE SIGNED: Jan 4. 53

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation — DATE THEREOF: Jan 6 1953 — NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory — LOCATION (City, town, or county) (State): Prince George County, Md.

DATE REC'D BY LOCAL REGISTRAR: Jan. 4, 1953 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR — ADDRESS: Annapolis, Md. — Ben L. Horning and Son

RECEIVED
JAN 7 19[illegible]
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 3 Maryland Ave

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 29 Murray Ave

3. NAME OF DECEASED (Type or Print): (First) ALFRED (Middle) W (Last) PHILLIPS

4. DATE OF DEATH (Month) JANUARY (Day) 2 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED

8. DATE OF BIRTH: Sept. 1, 1873

9. AGE last birthday: 79 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Buildings

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James E.V. Phillips

14. MOTHER'S MAIDEN NAME: Harriet Benjamin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No — No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Miss Margarie C. Phillips Daughter 4 Francis St. Annapolis, Md.

18. MEDICAL CERTIFICATION

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a): Gun shot wound in skull

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b):

(c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: 3 Maryland Ave (CITY OR TOWN): Annapolis, (COUNTY): Anne Arundel, (STATE): Maryland

TIME OF INJURY (Month) (Day) (Year) (Hour): 1-2-53 10 A m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?: Self inflicted

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Elmer C. Linhardt (Degree or title): Medical Examiner A.A. Co. ADDRESS: Annapolis, Maryland DATE SIGNED: 1-2-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 1-5-53

NAME OF CEMETERY OR CREMATORY: St. Anne's Cemetery

LOCATION (City, town, or county) (State): Annapolis Maryland

DATE REC'D BY LOCAL REG.: Jan. 5, 1953

REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: Ben L. Hopping and Son ADDRESS: Annapolis, Md

RECEIVED
JAN 7
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00126

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 1yr. 1½mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 2101 W. Coldspring Lane ✓

3. NAME OF DECEASED: (Type or Print) (First) Annie (Middle) (Last) Pollard

4. DATE OF DEATH: (Month) 1 (Day) 11 (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 1872?

9. AGE last birthday: 81? yrs. IF UNDER 1 YEAR Months – Days – IF UNDER 24 HRS. Hours – Min. –

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): ~~Unknown~~ Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): ~~Unknown~~ Eastern Shore Md.

12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: ~~Unknown~~ Levi James

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) – – –

16. SOCIAL SECURITY No.: – – – – –

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a)	Chronic Myocarditis Known to us adm.	since 11/27/51
DUE TO		
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)		
DUE TO		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

4222

19a. DATE OF OPERATION: – – – –

19b. MAJOR FINDINGS OF OPERATION – – – – – – – – – – – – – – – –

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) – – – –
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) – – – – – – (CITY OR TOWN) (COUNTY) (STATE) – – – – – – – –
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? – – – – – – –

22. I hereby certify that I attended the deceased from 11/27, 19 51 to 1/11, 19 53, that I last saw the deceased alive on 1/11, 19 53, and that death occurred at 9:10 p.m., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern M.D. (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 1/11/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1/14/1953
NAME OF CEMETERY OR CREMATORY Arlington Memorial
LOCATION (City, town, or county) (State) Arlington Md.

DATE REC'D BY LOCAL REGISTRAR 1/14/53
REGISTRAR'S SIGNATURE A W Hedrick
24. FUNERAL DIRECTOR Mrs Mabel Williams
ADDRESS Schroeder St.

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 1

1. PLACE OF DEATH:

COUNTY: Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville

LENGTH OF STAY (in this place): 18 yrs. 6 mos.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland COUNTY: Baltimore City

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City

STREET ADDRESS (If rural, give location): 508 Stricker Street ✓

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Amos		Powell	1	31,	19 53

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro	Married	1877?	76? yrs.	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Porter	Unknown	Maryland	U. S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Amos Powell	Elizabeth Richardson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
Unk.	— — —	Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
Immediate cause	(a) Pulmonary Tuberculosis	Known	to us since 1/19/53
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Chronic Myocarditis	Known	to us since 8/20/35
	DUE TO (c)		

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
— — — — — —	— — — — — — — — — — — — — — — —	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
— — — — — —	— — — — — — — — — — — — — — — —			

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
— — — — — — M.		— — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 10/13, 19 41 to 1/31, 19 53 that I last saw the deceased alive on 1/31, 19 53, and that death occurred at 11:05 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE): Jacob Marguerite M.D. ADDRESS: Crownsville, Md. DATE SIGNED: 1/31/53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb 5, 1953	Mt Auburn Cem	Balto	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/3/53		Mrs Katie R. Williams	Schroeder St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1 PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 2 yrs. 8 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
STREET ADDRESS (If rural give location): R. F. D. #3

3. NAME OF DECEASED: (Type or Print) (First) Nannie (Middle) Frances (Last) Powell
4. DATE OF DEATH: (Month) 1 (Day) 6 (Year) 19 53
5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 1871?
9. AGE last birthday: 82? yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: John P. Stockett
14. MOTHER'S MAIDEN NAME: Mary Powell
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No.
(If Yes, give war or dates of service) — —
16. SOCIAL SECURITY NO.: — — —
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

025X

Immediate cause (a) General Paresis — Interval Between Onset And Death: Known to us since adm. 4/7/49

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

11 OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — — —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) (COUNTY) (STATE) —
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 4/7 ,19 49, to 1/6 , 19 53 that I last saw the deceased alive on 1/6 , 19 53 and that death occurred at 5:25 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Carl Marquardt M.D.
ADDRESS: Crownsville, Md.
DATE SIGNED: 1/6/53

23. BURIAL, CREMATION, REMOVAL (Specify): Buried
DATE THEREOF: Jan 9 1953
NAME OF CEMETERY OR CREMATORY: Hanover-Asbury
LOCATION (City, town, or county) (State): Laurel Md.
DATE REC'D BY LOCAL REGISTRAR: 1-8-53
REGISTRAR'S SIGNATURE: T. M. Joyce
24. FUNERAL DIRECTOR: Robert L. Snowden
ADDRESS: Rockville

a.4

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The [illegible] is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH — COUNTY: A. A. Co. — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Harmans — LENGTH OF STAY (In this place): 58 yrs. — HOSPITAL OR INSTITUTION OR STREET ADDRESS: Dorsey-Harmans Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: A. A. Co. — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Harmans — STREET ADDRESS (If rural, give location): Dorsey-Harmans Rd

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Roland	R.	Ray	Jan. 13, 1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	W.	Married	May 6, 1894	58 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Carpenter	Chemicals	Harmans Md.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wesley Ray	Fannie Taylor (Margaret Frances Gaylor)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	215-07-7644	Mr. Walden Ray, Hanover, R 3 Sa. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Occlusion	45 min
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio-sclerosis & Hypertension	1 yr.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from....., 19....., to Jan. 13th, 1953 that I last saw the deceased alive on Jan. 13th, 1953, and that death occurred at 7 A. m. from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank Shipley	M. D.	Savage Md.	1/13/53

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/15/53	Meadowridge Mem. Pk.	Howard Co., Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/13/53	A. W. Hedrick JT	J. M. J. Pickner & Sons	Balto 17, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00130

CERTIFICATE OF DEATH

Reg. Dist. No. 2E

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 29 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 4 S. Regester Street

3. NAME OF DECEASED: (Type or Print) (First) Louis (Middle) (Last) Robinson

4. DATE OF DEATH: (Month) 1 (Day) 31 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 4/5/71?

9. AGE last birthday: 82? yrs. IF UNDER 1 YEAR Months – Days – IF UNDER 24 HRS. Hours – Min. –

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired). Street Worker

10b. KIND OF BUSINESS OR INDUSTRY: Unk.

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Peter Robinson

14. MOTHER'S MAIDEN NAME: Maetha Gilyard

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) – – –

16. SOCIAL SECURITY No.: – – –

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

025X

Immediate cause (a) General Paralysis of the Insane — Interval Between Onset And Death: Known to us since ad. 1/2/53

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) C N S Lues — " "

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Brain Syndrome due to CNS Syphilis (Meningoencephalitis) with Psychotic Reaction — " "

19a. DATE OF OPERATION: – – – – –

19b. MAJOR FINDINGS OF OPERATION – – – – –

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) – – – – – –
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) – – – – – (CITY OR TOWN) (COUNTY) (STATE) – – – – –
TIME OF INJURY (Month) (Day) (Year) (Hour) – – – – – m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? – – – – – – – –

22. I hereby certify that I attended the deceased from 1/2, 19 53, to 1/31, 19 53, that I last saw the deceased alive on 1/31, 19 53, and that death occurred at 8:00 p.m., from the causes and on the date stated above.

SIGNATURE [signature] M.D. (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 1/31/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 2/5/53
NAME OF CEMETERY OR CREMATORY NY Calvary Cem.
LOCATION (City, town, or county) (State) Brooklyn NY

DATE REC'D BY LOCAL REGISTRAR 2/4/53
REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Elroy O. Wilson ADDRESS 1000 Brantley

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harmon
LENGTH OF STAY (in this place) 2 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dorsey Road.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harmon
STREET ADDRESS (If rural, give location) Dorsey & Camp Meade Roads

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Lee (Last) Rush.
4. DATE OF DEATH: (Month) January (Day) 6 (Year) 1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male.	White	married	March-1889	63 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Ship Yd
11. BIRTHPLACE (State or foreign country) Sussex Milford Va.
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME ? Unknown
14. MOTHER'S MAIDEN NAME ? Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 223-12-2232.
17. INFORMANT AND ADDRESS Mrs. Mary Elizabeth Rush. (wife)

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause	(a) Coronary sclerosis	Sudden
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General Arteriosclerosis	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Lucius H. Rawlerson M.D. (Degree or title) Deputy Medical Examiner. ADDRESS Glen Burnie, Md. DATE SIGNED 1/6/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Jan. 9, 1953
NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery
LOCATION (City, town, or county) Glen Burnie, A.A.Co., Md. (State)

DATE RECD BY LOCAL REG. 1/8/53
REGISTRAR'S SIGNATURE A. W. Hedwig M.D.
24. FUNERAL DIRECTOR Wills Lamoreau ADDRESS 4510 Liberty Hgts Av

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, (19)13

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL) OR TOWN: Ferndale
LENGTH OF STAY (in this place): 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 2 Broadview Blvd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Same
COUNTY: A.A.Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Same
STREET ADDRESS (If rural give location): Same

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print): Mary Clare Sauerwald

4. DATE OF DEATH: (Month) (Day) (Year): January 18 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 3/10/11

9. AGE last birthday: 41 yrs. (IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.)

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arthur Layton

14. MOTHER'S MAIDEN NAME: Emma Rider

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): No

16. SOCIAL SECURITY No.: 216-05-4303

17. INFORMANT & ADDRESS: J. Sauerwald (Husband.)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Mitral Insufficiency — Interval Between Onset And Death: 4years

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — DUE TO (b) Chronic Interstitial nephritis — 4years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June ,1948, to Jan.18 ,1953, that I last saw the deceased alive on Jan.16 ,1953, and that death occurred at 4.50 P.M., from the causes and on the date stated above.

SIGNATURE: Medical Examiner
(Degree or title)
ADDRESS: Glen Burnie, Md.
DATE SIGNED: Jan.18 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 1/21/53
NAME OF CEMETERY OR CREMATORY: Glen Haven
LOCATION (City, town, or county) (State): Glen Burnie, Md.

DATE REC'D BY LOCAL REGISTRAR: 1/19/53
REGISTRAR'S SIGNATURE: L. J. DeAlba

24. FUNERAL DIRECTOR: R.V. Singleton, Glen Burnie, Md.
ADDRESS

VS. A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 1

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. G. General

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 621 Sixth St.

3. NAME OF DECEASED: (Type or Print) (First) Frederick (Middle) (Last) Segelken

4. DATE OF DEATH: (Month) 1 (Day) 14 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: Dec. 13-1864

9. AGE last birthday: 88 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Engineer

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Segelken

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT'S ADDRESS: Fred Segelken Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Arteriosclerosis Heart	Several yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Senile. DUE TO	
	(c) Generalized Arteriosclerosis DUE TO	Several yrs
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.	Benign Prostatic Hypertrophy	3 years

42.1.0

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-24, 1952, to 1-14, 1953, that I last saw the deceased alive on 1-14, 1953, and that death occurred at 8.30 p.m., from the causes and on the date stated above.

SIGNATURE George C Beall M.D (DEGREE OR TITLE) Annapolis Md (ADDRESS) DATE SIGNED Jan 15-53

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify): — DATE THEREOF 1-18-53 — NAME OF CEMETERY OR CREMATORY Cedar Bluff — LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Jan. 16, 1953 — REGISTRAR'S SIGNATURE [illegible] — 24. FUNERAL DIRECTOR John M. Taylor & Son ADDRESS Annapolis md.

B.W.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: P.O. Pasadena — LENGTH OF STAY (In this place): 9 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Outing and W. Avenue Green Haven

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Same — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Same
STREET ADDRESS (If rural, give location): Outing and X Avenue Green Haven

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) B. (Last) Singer

4. DATE OF DEATH: (Month) (Day) (Year) January 5 1953

5. SEX: Male — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married — 8. DATE OF BIRTH: 3/4/1900 — 9. AGE last birthday: 52 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wholesale Produce — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Baltimore, Md. — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Simon Singer — 14. MOTHER'S MAIDEN NAME: Jennie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: — 17. INFORMANT AND ADDRESS: Mrs Lillian M Singer, (wife).

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Hemorrhage due to decapitation caused by	
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) automobile accident.	Sudden
(c) Diabetes	?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

E 819.1 (260)

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION: — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Avenue — (CITY OR TOWN) (COUNTY) (STATE): Green Haven, Pasadena, A.A. Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): I/5/52 IO A. m. — INJURY OCCURRED While at work ☒ Not while at work ☐ — HOW DID INJURY OCCUR?: Automobile hit a tree.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Gustave A Rauchfuss — (Degree or title): Deputy Medical Examiner — ADDRESS: Glen Burnie, Md. — DATE SIGNED: I/5/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1-6-53 — NAME OF CEMETERY OR CREMATORY: Rosedale — LOCATION (City, town, or county) (State): Balto Md

DATE RECD BY LOCAL REG. 1/6/53 — REGISTRAR'S SIGNATURE: A.W. Hedrick — 24. FUNERAL DIRECTOR: Jack Lewis Bro — ADDRESS: 2100 Eutaw Pl

Duke

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 72 College Creek Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland Anne Arundel COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 72 College Creek Terrace

3. NAME OF DECEASED (Type or Print): (First) Florence (Middle) Elizabeth (Last) Simms
4. DATE OF DEATH: (Month) 1/5/ (Day) (Year) 1953 19

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed
8. DATE OF BIRTH: 5/10/1871
9. AGE last birthday: 81 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laundress-Naval Academy
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Harwood, A. A. Co. Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Morgan
14. MOTHER'S MAIDEN NAME: Ellen Moulden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ---
17. INFORMANT AND ADDRESS: Henrietta Mc Gowns-113 Clay St. Annapolis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Uterus — Interval Between Onset and Death: 1 yr

174X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

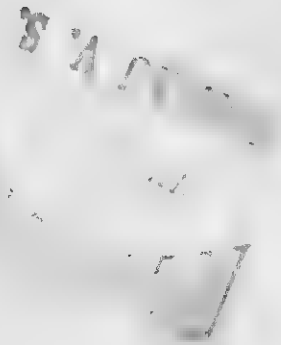
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1953, to Jan 5, 1953, that I last saw the deceased alive on Jan 5, 1953, and that death occurred at 1:20 P m., from the causes and on the date stated above.

SIGNATURE: R. L. Richardson (Degree or title) M.D. ADDRESS 110 - Clay St Annapolis Md. DATE SIGNED 1/7/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 1/9/1953
NAME OF CEMETERY OR CREMATORY: Brewer Hill Cemetery
LOCATION (City, town, or county) (State): West St. Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Jan 9, 1953
REGISTRAR'S SIGNATURE: W. O'Donnell
24. FUNERAL DIRECTOR: Mrs. Ethel L. Hicks-45 Northwest St. Annapolis, Md.
ADDRESS



Film G150, Item #9
1/21/53, mnd
Item 7 Film G150 1/23/53 mhw

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN: Crownsvilles
LENGTH OF STAY (in this place): 24yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BERLIN
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Gordon (Last) Smack

4. DATE OF DEATH: (Month) 1 (Day) 10 (Year) 19 53

5. SEX: MALE

6. COLOR OR RACE: A.A.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 9-15-1875

9. AGE last birthday: 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: FARM WORK

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Smack

14. MOTHER'S MAIDEN NAME: Annie Smack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: TAKEN from Hosp. RECORDS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) ~~PNEUMONIA~~ ~~ARTERIO VASCULAR DISEASE~~ SEPTICEMIA

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) INFECTED EXTENSIVE DECUBITI

DUE TO (c) (IN AN ELDERLY DEBILITATED MAN)

715+

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-22 ,19 50., to 1-10 , 19 53, that I last saw the deceased alive on 1-10 1953, and that death occurred at 11 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

[signature] M.D. — Crownsville St. Hosp — 1-11-53

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE THEREOF: 1-14-53 — NAME OF CEMETERY OR CREMATORY: EVERGREEN — LOCATION (City, town, or county) (State): BERLIN, WORCESTER, Md.

DATE REC'D BY LOCAL REGISTRAR: 1-11-53 — REGISTRAR'S SIGNATURE: Kim. Joyce

24. FUNERAL DIRECTOR: Stewart FUNERAL HOME — ADDRESS: 324 E. Church St Salisbury, Md.

Thornton B. Jolley

VS. A15

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.........................

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 3 yrs. 5 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural, give location) 302 N. High Street ✓

3. NAME OF DECEASED: (Type or Print) (First) Edgar (Middle) (Last) Smith

4. DATE OF DEATH: (Month) 1 (Day) 31 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1880?

9. AGE last birthday: 73? yrs. IF UNDER 1 YEAR Months – Days – IF UNDER 24 HRS. Hours – Min. –

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) – – – – – –

16. SOCIAL SECURITY No.: – – – – – –

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 442X

		Interval Between Onset and Death
Immediate cause	(a) Chronic Myocarditis	Known to us since 8/27/49
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Cardio-renal Disease	" " " "
DUE TO	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: – – – – – –

19b. MAJOR FINDINGS OF OPERATION: –

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) – – – – – – PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) – – – – – – – (CITY OR TOWN) (COUNTY) (STATE) – – – – – – – – – – – – – – – –

TIME OF INJURY (Month) (Day) (Year) (Hour) – – – – – – M. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR? – – – – – – – – – – – –

22. I hereby certify that I attended the deceased from 8/27, 19 49, to 1/31, 19 53, that I last saw the deceased alive on 1/31, 19 53, and that death occurred at 11:00 p.m., from the causes and on the date stated above.

SIGNATURE Jacob [signature] M.D. (DEGREE OR TITLE) ADDRESS Crownsville, Md. DATE SIGNED 1/31/53

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF Feb. 6/53 NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem. LOCATION (City, town, or county) A. A. County (State) Md.

DATE REC'D BY LOCAL REG. 2/5/53 REGISTRAR'S SIGNATURE [signature] **24. FUNERAL DIRECTOR** Mrs Robert A. Elliott & Daughter ADDRESS 1124 W. Caroline St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 82 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Arnold
STREET ADDRESS (If rural, give location): Smith's Trailer Park

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Octavia (Last) SMITH

4. DATE OF DEATH: (Month) (Day) (Year) January 25 19 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: August 13, 1876

9. AGE Last birthday: 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Red Springs, North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Luther H. HIGHSMITH

14. MOTHER'S MAIDEN NAME: Mary Octavia DeVon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: (Son) Joseph R. SMITH, Smith's Trailer Park, Arnold, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

903.0 Immediate cause (a) FRACTURE OF NECK OF FEMUR (N820) — Interval Between Onset And Death: 82 days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. ARTERIOSCLEROSIS GENERAL (450.0) — 15 years

19a. DATE OF OPERATION: November 8, 1952

19b. MAJOR FINDINGS OF OPERATION: FRACTURE OF NECK OF FEMUR

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home — (CITY OR TOWN): Arnold — (COUNTY): Anne Arundel — (STATE): Maryland

TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 5, '52 10:00 A.M.

INJURY OCCURRED: While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Fell on way to bathroom

22. I hereby certify that I attended the deceased from 5 Nov, 19 52, to 25 Jan, 19 53, that I last saw the deceased alive on 25 Jan, 19 53, and that death occurred at 9:15 P.m., from the causes and on the date stated above.

SIGNATURE: R.M. DIMMETTE, LT MC USN — (DEGREE OR TITLE) ADDRESS: U.S. Naval Hospital, Annapolis, Md. — DATE SIGNED: 1-26-53

23. BURIAL, CREMATION REMOVAL (Specify): Removal — DATE THEREOF: Jan. 26, 1953 — NAME OF CEMETERY OR CREMATORY: to — LOCATION (City, town, or county) (State): ABINGDON, VIRGINIA

DATE REC'D BY LOCAL REG.: Jan. 26, 1953 — REGISTRAR'S SIGNATURE: B.W.

24. FUNERAL DIRECTOR: Ben L. Hopping and Son — ADDRESS: Annapolis, Md.

VS. A15 [illegible]

RECEIVED
JAN 21
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13-24

VS. A15 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

COUNTY A.A. — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glenburnie

LENGTH OF STAY (in this place) 6 mos.

HOSPITAL OR INSTITUTION OR STREET ADDRESS 609 Binstead Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hammdale (Glen Burnie P.O.)

STREET ADDRESS (If rural, give location) 609 Binstead Rd.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Marianne	Marie	Spangler	Jan	19	1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
F	W	Single	June 18-1952	yrs.	6			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
None	—	Baltimore Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Louis Leo Spangler	Barbara Mae Case

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	None	Mother.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Meningitis (Spinal) — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Cold — 2 days

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Jan 17, 1953, to Jan 19, 1953, that I last saw the deceased alive on ....., 19....., and that death occurred at 10 A.M., from the causes and on the date stated above.

SIGNATURE Alex. L. Bach Jr. (DEGREE OR TITLE) Physician ADDRESS — DATE SIGNED 1/19/53

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	1/20/53	Glen Haven	Glen Burnie	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/19/53	L. J. De Alba	P.V. Singleton	Glen Burnie, Md.

20621914 04

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 51

1. PLACE OF DEATH:
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 13 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: ~~Baltimore~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore Cty.
STREET ADDRESS (If rural, give location): 1215 Valley Street ✓

3. NAME OF DECEASED (Type or Print): (First) Peter (Middle) Martin (Last) SPORRER, Jr.

4. DATE OF DEATH: (Month) January (Day) 19 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: September 19, 1886

9. AGE last birthday: 66 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Martin SPORRER, Sr. (Deceased)

14. MOTHER'S MAIDEN NAME: Josephine Loesch (Deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes
(If Yes, give war or dates of service) WWI

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: (Sister) Elizabeth E. Wellein, 1215 Valley St., Balto., Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) ULCER, PEPTIC, OF DUODENUM WITH PERFORATION (541.1)	24 hrs.
	DUE TO	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	
	DUE TO	
	(c)	

541.1

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. ATELECTASIS, LEFT LUNG, CAUSE UNDETERMINED (527) 12 hrs.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19 Jan., 19 53, to 19 Jan., 19 53, that I last saw the deceased alive on 19 Jan., 19 53, and that death occurred at 1:10 p.m., from the causes and on the date stated above.

SIGNATURE: R.K. MOXON, LCDR MC USN
(DEGREE OR TITLE) ADDRESS: U.S. Naval Hospital, Annapolis, Md.
DATE SIGNED: 1-20-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 1/22/53
NAME OF CEMETERY OR CREMATORY: Balto. National
LOCATION (City, town, or county) (State): Balto MD

DATE REG'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: L.J. Ruck
ADDRESS: 5305 Harford Rd.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Maryland
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS USNH, Annapolis, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 3848 Falls Road

3. NAME OF DECEASED: (Type or Print) (First) Doris (Middle) Virginia (Last) STERNER

4. DATE OF DEATH: (Month) January (Day) 25 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 29, 1919

9. AGE last birthday: 33 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk Housewife

10b. KIND OF BUSINESS OR INDUSTRY: 5 & 10 Store

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles MARSTON

14. MOTHER'S MAIDEN NAME: Eloise PALMER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 215-09-7777

17. INFORMANT & ADDRESS: Warren Marvin STERNER 3848 Falls Road, Baltimore, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

401.1 Immediate cause (a) SUBACUTE BACTERIAL ENDOCARDITIS, ORGANISM UNDETERMINED #430.0 — Interval between onset and death: 60 days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) RHEUMATIC HEART DISEASE, CHRONIC #416 — 10 years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. ANEMIA, SEVERE, OF INFECTION #293 — 35 days

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 20 Jan, 1953, to 25 Jan, 1953, that I last saw the deceased alive on 25 Jan, 1953 and that death occurred at 10:03 a.m., from the causes and on the date stated above.

SIGNATURE R.M. DIMMETTE (DEGREE OR TITLE) LT., MC, USN ADDRESS USNH, ANNAPOLIS, MARYLAND DATE SIGNED 25 JAN 1953

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE THEREOF Jan. 29, 1953 NAME OF CEMETERY OR CREMATORY St. Mary's (Hampden) LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE REC'D BY LOCAL REG. 1/28/53 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Burgee Funeral Home ADDRESS 3631 Falls Road

Horace F. Burgee

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11114 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Solley
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Solley Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Solley
STREET ADDRESS (If rural, give location): Solley Rd. Box 146 Route #1

3. NAME OF DECEASED (Type or Print): (First) Ethel (Middle) Maud (Last) Tabb

4. DATE OF DEATH (Month) (Day) (Year): January 17, 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: Feb. 19, 1886

9. AGE last birthday: 66 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James E. Sanders

14. MOTHER'S MAIDEN NAME: Jessie M. Denniford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs. Eva Strong Solley, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a): Chronic myocarditis.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): Diabetes mellitus.

(c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 7, 1952, to Jan 17, 1953, that I last saw the deceased alive on Jan 15, 1953, and that death occurred at 9 00 P.M., from the causes and on the date stated above.

SIGNATURE: Jesse E. Shannon M.D. (Degree or title) — ADDRESS: 820 Medical Arts Bldg. — DATE SIGNED:

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 1-20-1953 — NAME OF CEMETERY OR CREMATORY: Lorraine Park — LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE REC'D BY LOCAL REG.: 1-19-53 — REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR — ADDRESS: G. Howard Strong 3207 W. North Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton | LENGTH OF STAY (in this Place) 7½ yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Odenton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton, Md.
STREET ADDRESS (If rural, give location) Odenton, Md.

3. NAME OF DECEASED (Type or Print): (First) Clarence (Middle) T. (Last) TOPPIN

4. DATE OF DEATH: (Month) 1 (Day) 18 (Year) 1953

5. SEX: Male | 6. COLOR OR RACE: Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: 3-31-1[illegible] | 9. AGE last birthday: 71 yrs. | If under 1 year: Months [illegible] Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer | 10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt. | 11. BIRTHPLACE (State or foreign country): Accomac, Va. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas J. Toppin | 14. MOTHER'S MAIDEN NAME: Ella Toppin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO | (If yes, give war or dates of service): NO | 16. SOCIAL SECURITY NO. 225-18-5[illegible] | 17. INFORMANT AND ADDRESS: Lily Toppin - Odenton, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

+ Immediate cause (a) Tuberculosis of the lungs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: [illegible] about 15 weeks DHM'N

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-18A, 19..... to 6 PM 19....., that I last saw the deceased alive on Jan 18, 1953 and that death occurred at 5P m., from the causes and on the date stated above.

SIGNATURY: Horace Neamar (Degree or title) ADDRESS Millersville Md DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): Buried | DATE THEREOF 1-21-1953 | NAME OF CEMETERY OR CREMATORY Mt. Lebanon | LOCATION (City, town, or county) Chesterfield (State) Md.

DATE REC'D BY LOCAL REG. 1/20/53 | REGISTRAR'S SIGNATURE A W Hawkins | 24. FUNERAL DIRECTOR William Buser ADDRESS 108 N. Washington St Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 519 Scott St.

3. NAME OF DECEASED: (Type or Print) (First) Clarence (Middle) E. (Last) Tyler

4. DATE OF DEATH: (Month) 1 (Day) 1 (Year) 1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	11-8-1887	65 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Paint Contractor	Self Employed	Sommerset Co Md.	U.S.A.

13. FATHER'S NAME: Edward Tyler

14. MOTHER'S MAIDEN NAME: Amanda Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) —

16. SOCIAL SECURITY NO.: (If Yes, give war or dates of service) —

17. INFORMANT & ADDRESS: Mrs Robert Elliott Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Acute Coronary Thrombosis	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Pernicious Coronary Attacks	about 1 yr
	(c) Arterial Hypertension	Several yrs

420.1

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Dec 24, 1952, to Dec 31, 1952, that I last saw the deceased alive on Dec 31, 1952, and that death occurred at 9:45 a.m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
J. Oliver Pereira	M.D.	Annapolis Maryland	1-2-53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	1-5-53	Cedar Bluff	Annapolis	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan 4 1953	[signature]	John M. Hayes Sons	Annapolis Md.

RECEIVED
JAN 7 1[illegible]
BUREAU V. S.

1070

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville

LENGTH OF STAY (in this place): Life

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Dorrs Corner

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland — COUNTY Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville

STREET ADDRESS (If rural give location): Dorrs Corner

3. NAME OF DECEASED: (Type or Print) (First) Arthur (Middle) S. (Last) Watkins

4. DATE OF DEATH: (Month) January (Day) 14, (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Aug. 10, 1872

9. AGE last birthday: 80 yrs. — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Paperhanger

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George G. Watkins

14. MOTHER'S MAIDEN NAME: Mary Jane Phelps

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) —

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Mrs. Daisy C. Wiggly — Millersville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 3 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Femoral Arterio-Sclerosis — + 8 yrs.

DUE TO (c) Coronary disease — + 3 y.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. —

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to January 14, 1953, that I last saw the deceased alive on Jan 12, 1953, and that death occurred at 12:50 A.M., from the causes and on the date stated above.

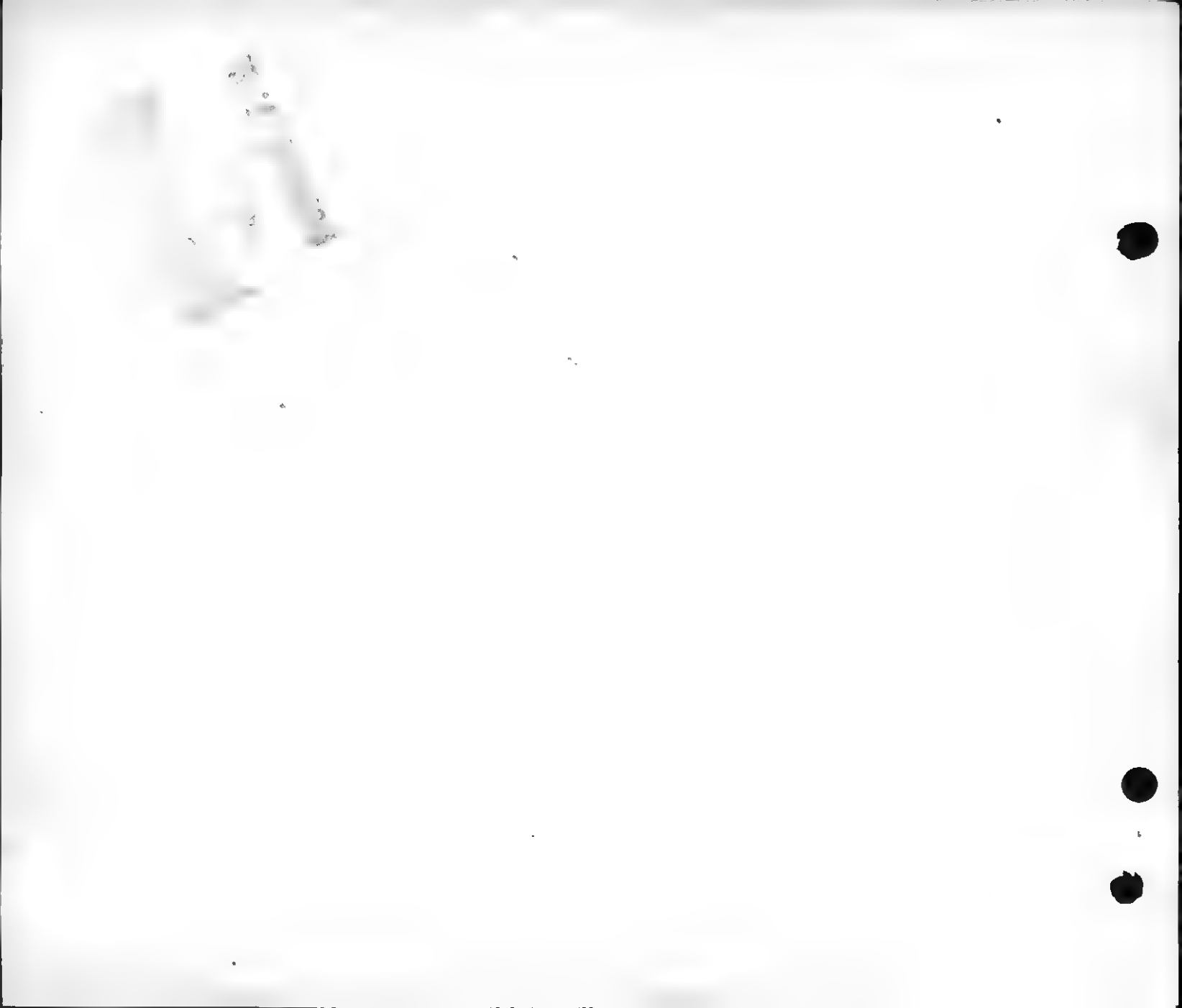
SIGNATURE (Degree or title) Gustave A. Bauernschmidt. — ADDRESS Glen Burnie Md. — DATE SIGNED 1/15/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1-16-53 — NAME OF CEMETERY OR CREMATORY Baldwin Meth. Ch. Cem. — LOCATION (City, town, or county) (State) Severn Crossroads, Millersville Md.

DATE REC'D BY LOCAL REGISTRAR 1/16/53 — REGISTRAR'S SIGNATURE L. J. DeAlba

24. FUNERAL DIRECTOR P. V. Singleton, Glen Burnie, — ADDRESS

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY: Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie

LENGTH OF STAY (in this place): Life

HOSPITAL OR INSTITUTION OR STREET ADDRESS: #7 14 st. N. E.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie

STREET ADDRESS (If rural give location): 7 14 st. N. E.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Marion	Winfield	Watts	January	6	1953

5. SEX	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	May 25, 1903	49				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Longshoreman	Waterfront Co.	Glen Burnie, Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Mahlon Watts	Mary Watts

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
	215-03-7545	Mrs. Beatrice Watts Glen Burnie, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause — (a) Coronary Occlusion

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Atherosclerosis

DUE TO

(c) Chest

Interval Between Onset And Death: 8 wks

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/ /, 1952 to 1/6, 1953, that I last saw the deceased alive on 1/2, 1953, and that death occurred at 6 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J.W. Cuchard		Glen Burnie Md	1/7/53

23. BURIAL, CREMATION, REMOVAL. (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/8/53	Glen Haven	Glen Burnie, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/8/53	L.J. Dellen	P.V. Singleton	Glen Burnie, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible] 56

CERTIFICATE OF DEATH

Reg. Dist. No. 52

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legib.

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Friendship
LENGTH OF STAY (in this place) 40 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Friendship
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Anna (Middle) Hope (Last) Webb

4. DATE OF DEATH: (Month) 1 (Day) 8 (Year) 1953

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: July 5 1885

9. AGE last birthday: IF OVER 1 YEAR 67 yrs. IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Postmistress

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Postal Service

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Benjamin Jones

14. MOTHER'S MAIDEN NAME: L. Miranda Talbott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Thomas H. Webb Friendship, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary occlusion

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) arteriosclerosis

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/22, 1952, to 1/7, 1953, that I last saw the deceased alive on 1/7, 1953, and that death occurred at 12:30 AM from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

C. H. Willems M.D. Huntingtown Md 1/10/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 1/10/53

NAME OF CEMETERY OR CREMATORY Friendship Cemetery

LOCATION (City, town, or county) (State) Friendship, Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 10, 1953

REGISTRAR'S SIGNATURE Grace L. Hutchins

24. FUNERAL DIRECTOR ADDRESS Wm. H. Hutchins, Owings, Md.

Jan 13, - 1953 M.R. Clayton M.D. Dent-me

DATE
JAN
BUREAU V. S.
SENT TO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 51

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Annapolis, Md.
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Clinton (Millersville P.O.)
STREET ADDRESS (If rural, give location) Enright Road

3. NAME OF DECEASED: (Type or Print) (First) Jerry (Middle) Elwood (Last) White

4. DATE OF DEATH: (Month) Jan. (Day) 20, (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Aug. 20, 1950

9. AGE last birthday: 2 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter White

14. MOTHER'S MAIDEN NAME: Eleanore Berry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs. Eleanore White - Clinton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

340.3

Immediate cause (a) MENINGITIS — Interval between onset and death: ? 2 WEEKS

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) DUE TO
(c)

47-X1

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. ACUTE TONSILLITIS — 5-6 DAYS

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION:**

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/16, 19 53, to 1/20, 19 53, that I last saw the deceased alive on 1/20, 19 53, and that death occurred at 8 P m., from the causes and on the date stated above.

SIGNATURE Philip Bruce (DEGREE OR TITLE) M.D. ADDRESS 212 Prince George St Annapolis DATE SIGNED 1/20/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 1-23-53 — NAME OF CEMETERY OR CREMATORY Glen Haven — LOCATION (City, town, or county) Glen Burnie (State) Md.

DATE REC'D BY LOCAL REG. 1/23/53 — REGISTRAR'S SIGNATURE Wm. J. French - CMC

24. FUNERAL DIRECTOR T. F. Singleton — ADDRESS Glen Burnie, Md.

Item 7, FilmG150, 1/14/53, mnb

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 51

1. PLACE OF DEATH:
COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD COUNTY A A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Jane (Last) Wilkerson

4. DATE OF DEATH: (Month) Jan (Day) 1 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct 10 1890

9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Churchton Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Blunt

14. MOTHER'S MAIDEN NAME: Mary Alice Hutton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Charles Blunt, Churchton, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Diabetic Coma	3 wks
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Diabetes Mellitus	?
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Amnesia (Conversion Hysteria) 3 wks.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, OF bldg., etc.) INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-11-, 1952, to 1-1-, 1953, that I last saw the deceased alive on 1-1-, 1953, and that death occurred at 11:45 P.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Frank W. Shipley M.D. Annapolis, 1/2/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF Jan 5, 1953
NAME OF CEMETERY OR CREMATORY Franklin
LOCATION (City, town, or county) (State) Churchtown Md.

DATE REC'D BY LOCAL REG. Jan. 5, 1953
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR ADDRESS T.A. Hardesty & Sons, Odenville, Md.

RECEIVED
JAN 7 1933
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 0015

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 51

1. PLACE OF DEATH:

COUNTY Ca. A. — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cedar Hill — LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Anne Arundel Co.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cedar Hill, Balto 25.

STREET ADDRESS (If rural, give location) 221 Cedar Hill Lane

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Ella		Williams	Jan	30	53

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	Colored	Widow	June	78 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
		Baeto	

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Unknown	Kate Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Rodell Williams. Cedar Hill Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Lobar Pneumonia	1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Cerebral Infarct.	2 wks
	(c) DUE TO Senility & Intermediate	2 years

490.1

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐
—	—	

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1 —, 1953, to Jan 30, 1953, that I last saw the deceased alive on Jan 29. 53, and that death occurred at 7.20 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

M.D. Deputy M.E. Clinton Md Jan 31 53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb 2. 53	Mt Calvary	A.A. Co. Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/2/53	J. W. Hedrick JT	James A. Staylor	638 N. Gilmor

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 ... 51

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel Genual

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 816 West Street

3. NAME OF DECEASED: (First) Lily (Middle) (Last) Williams
4. DATE OF DEATH: (Month) January (Day) 10 (Year) 1953
5. SEX: Female
6. COLOR OR RACE: White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify):
8. DATE OF BIRTH: July 29, 1879
9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unk
14. MOTHER'S MAIDEN NAME: Unk
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Clarence E. Williams Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
422.1 Immediate cause	(a) Myocardial failure (cause)	2hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO arteriosclerotic cardiovascular disease	10 yrs
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 19 50, to Jan 10, 1953, that I last saw the deceased alive on Jan 10, 1953, and that death occurred at 5:08 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
J. Bowers M.D Annapolis Md 1/10/53

23. BURIAL, ~~CREMATION~~ ~~REMOVAL (Specify)~~: DATE THEREOF 1-13-53 NAME OF CEMETERY OR CREMATORY Cedar Bluff LOCATION (City, town or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Jan. 12, 1953 REGISTRAR'S SIGNATURE J. C. Bowers B.W. 1247 FUNERAL DIRECTOR John B. Taylor & Son ADDRESS Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00152

CERTIFICATE OF DEATH

Reg. Dist. No. 7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Crownsville
LENGTH OF STAY (in this place) 9½ months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY St. Mary's
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlotte Hall
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) W. (Last) Willis

4. DATE OF DEATH: (Month) 1 (Day) 27 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: may 16 1882

9. AGE last birthday: 70 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Charles Willis

14. MOTHER'S MAIDEN NAME: Julia Dent

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) — — — —

16. SOCIAL SECURITY No.: Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized Arteriosclerosis — Known adm. — Interval Between Onset And Death: to us since 4/2/52

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. 420.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — — — — —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — — — — —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — — — — — —

(CITY OR TOWN) (COUNTY) (STATE) —

TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 4/2 ..., 19 52, to 1/27 ..., 19 53 that I last saw the deceased alive on 1/27 ..., 19 53, and that death occurred at 7:28 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Robt Marquette M D

ADDRESS Crownsville Md.

DATE SIGNED 1/27/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Jan 30th 53 — NAME OF CEMETERY OR CREMATORY St. Maries — LOCATION (City, town, or county) St. Maries Co. — (State) Md.

DATE REC'D BY LOCAL REGISTRAR 1-31-53

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Elroy O Wilson — ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18[illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 11

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 249 Hanover St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 249 Hanover St.

3. NAME OF DECEASED: (Type or Print) (First) Annie (Middle) (Last) Wilson

4. DATE OF DEATH: (Month) January (Day) 10 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH: April 11 1865

9. AGE last birthday: 87 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unk.

14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Daniel Parkinson, Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.0
Immediate cause (a) Myocardial Insufficiency — Interval between onset and death: 3 days
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Arteriosclerotic Heart Disease — 2 Yrs.
DUE TO
(c) Senility — 4 Yrs.

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-9, 1953, to 1-10, 1953, that I last saw the deceased alive on 1-10, 1953, and that death occurred at 7:40 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) James R. Stanton M.D. ADDRESS Annapolis, Md. DATE SIGNED 1-10-53

23. BURIAL, CREMATION REMOVAL (Specify): DATE THEREOF 1-13-53 NAME OF CEMETERY OR CREMATORY St. Anne's LOCATION (City, town, or county) (State) Annapolis, Md.

DATE REC'D BY LOCAL REG. Jan. 12, 1953 REGISTRAR'S SIGNATURE [signature] BW

24. FUNERAL DIRECTOR John M. Taylor & Son ADDRESS Annapolis, Md.

Item 4, Feb 1950
1/Feb 53 mnt.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 (1-51)

1

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 511 Chesapeake Ave.

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) Emory (Last) Wilson

4. DATE OF DEATH: (Month) Jan (Day) 9 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify):

8. DATE OF BIRTH: June 6, 1879

9. AGE last birthday: 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician Ret.

10b. KIND OF BUSINESS OR INDUSTRY: U.S.N.A.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Wilson

14. MOTHER'S MAIDEN NAME: Tydings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: George S. L. Wilson - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Intestinal Obstruction	5 days
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Carcinoma descending Colon	6 Months
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis Senile

19a. DATE OF OPERATION: Jan. 4. 53

19b. MAJOR FINDINGS OF OPERATION: Annular Ca descending Colon

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 3, 1953, to Jan 9, 1953, that I last saw the deceased alive on Jan 9, 1953, and that death occurred at 5 p.m., from the causes and on the date stated above.

SIGNATURE: George C Bond — (DEGREE OR TITLE) M. D — ADDRESS Annapolis Md — DATE SIGNED 1-11-53

23. BURIAL, ~~CREMATION~~ ~~REMOVAL (Specify)~~: — DATE THEREOF 1-12-53 — NAME OF CEMETERY OR CREMATORY: Cedar Bluff — LOCATION (City, town, or county) (State): Annapolis Md.

DATE REC'D BY LOCAL REG.: Jan. 12, 1953 — REGISTRAR'S SIGNATURE: [illegible] — **24. FUNERAL DIRECTOR** — ADDRESS: John M. Taylor & Son - Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00155

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Magothy Pk. Beach
LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. F. D. #6 Box 38

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Magothy Park Beach
STREET ADDRESS (If rural, give location) R. F. D. - 6 Box 38

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Sarah	Jane	Woodland	Jan.	1,	1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Colored	Widow	July 30, 1867	85 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Baltimore, Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Nathaniel Grooms	Elizabeth Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT'S ADDRESS: Mrs. Lizzie Thomas Magothy Pk. Beach R.F.D. - 6 Box - 38

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
450.0 Immediate cause	(a) Cardiac decompensation	1 month
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) arteriosclerosis	not determined
DUE TO		
	(c) old age	not determined

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 17, 1952 to Jan. 1, 1953 that I last saw the deceased alive on Dec. 31, 1952, and that death occurred at 1:10 P.M., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
R. M. McLaughlin	M.D.	Pasadena P.O. Md.	Jan. 1. 1953

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 5, 1953	New Cathedral	Baltimore, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
January 3. 1953.	R.W.	Metcalf Funeral Home	1631 Druid Hill Ave

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY A.A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena. | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Doris (Middle) N. (Last) Janney
4. DATE OF DEATH: (Month) 1. (Day) 27 (Year) 1953.
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.
8. DATE OF BIRTH: 11.12.1877
9. AGE last birthday: 30 yrs. | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: B. R.R.
11. BIRTHPLACE (State or foreign country): Balto.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Wm. J. Sanford
14. MOTHER'S MAIDEN NAME: Ida Geoff
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. | (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Fam. Cy - James

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170X
Immediate cause (a) Carcinoma of right breast — Interval Between Onset And Death: 1½ yrs.
DUE TO

Antecedent causes (s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) metastases of carcinoma of breast — 1 yr.
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 20, 1952, to Jan. 27, 1953, that I last saw the deceased alive on Jan. 27, 1953, and that death occurred at 1:20 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Randall M. McLaughlin, M.D. | Pasadena. Md. | Jan. 27. 1953

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)
Burial | 1.29.53 | Balto. Nat. | Balto.

DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS
1/28/53 | H.W. Redrup | James L. McCauley | 130 E. Fort Ave.